

Personal Support Workers' Experience of Collaboration
in a Long-term Care Facility in Rural Ontario

Katie M. Hoogeveen

Submitted in partial fulfillment of the requirements for the degree of
Master of Arts in Applied Health Sciences
(Community Health)

Faculty of Applied Health Science, Brock University
St. Catharines, Ontario

© January, 2016

Abstract

The growing complexity of healthcare needs of residents living in long-term care necessitates a high level of professional interdependence to deliver quality, individualized care. Personal support workers (PSWs) are the most likely to observe, interpret and respond to resident care plans, yet little is known about how they experience collaboration. This study aimed to describe PSWs' current experiences with collaboration in long-term care and to understand the factors that influenced their involvement in collaboration. A qualitative approach was used to interview eight PSWs from one long-term care facility in rural Ontario. Thematic analysis revealed three themes: valuing PSWs' contributions, organizational structure, and individual characteristics and relationships. Collaboration was a difficult process for PSWs who felt largely undervalued and excluded. To improve collaboration, management needs to provide opportunities for PSWs to contribute and support the development of relationships required to collaborate.

Acknowledgements

My life has changed substantially since I began my Masters of Applied Health Science in September 2013. Since that date, I moved back to the Ottawa area, purchased my first home and returned to work full-time as a research associate, all while completing my graduate education. The enormous support from my family, particularly my parents Mike and Wendy, and my partner Brent has enabled me to complete this degree. Their encouragement, love, and support was unwavering throughout this process and allowed me to achieve a number of goals personally and professionally. I consider myself lucky to also have friends who have sustained me throughout this adventure.

I would like to thank Dr. Dawn Prentice for giving me the opportunity to work with her. Her willingness to allow me to work on my thesis from a distance, all while knowing her support was just a phone call or email away, was invaluable. This thesis would not have been possible without her patience, guidance, and dedication. I would also like to thank my committee members. To Dr. Jane Moore, Dr. Joyce Engel, and Dr. Carrie Mines, I extend my deepest appreciation for your commitment to my work.

Finally, I would like to thank the Chief Research Officer associated with the long-term care home in this study. Your interest in my work and the assistance you provided, particularly in gaining access to the home and participants, is much appreciated. Thank you to all of the women who agreed to participate in this study in spite of their initial reservations. Without their involvement, this thesis would not have been possible.

Tables of Contents

Abstract	ii
Acknowledgements	iii
Table of Contents	iv
 Chapter 1: Introduction	 1
Purpose of Study	5
 Chapter 2: Review of the Literature	 7
Movement Towards Person-Centered Care	7
<i>Collaborative Decision-Making.....</i>	<i>9</i>
Interprofessional Collaboration	9
<i>Conceptual Framework</i>	<i>12</i>
Collaboration in Long-term Care	14
<i>Outcomes of Collaboration in Long-term Care.....</i>	<i>15</i>
PSWs in Collaborative Practice	16
<i>Proximity to Residents</i>	<i>17</i>
Staff Communication and Relationships	18
<i>Nurse/Personal Support Worker Relationship.....</i>	<i>20</i>
<i>Staff Empowerment</i>	<i>21</i>
Summary	22
 Chapter 3: Methodology.....	 23
Qualitative Description.....	23
<i>Reflexivity/Role of the Research</i>	<i>24</i>
Sample Size & Participant Selection.....	26
<i>Sample Size</i>	<i>26</i>
<i>Participant Selection</i>	<i>26</i>
<i>Gaining Entry.....</i>	<i>27</i>
<i>Recruitment</i>	<i>27</i>

Data Collection.....	28
Data Analysis	29
<i>Thematic Analysis</i>	29
Trustworthiness & Authenticity	31
<i>Credibility</i>	32
<i>Transferability</i>	34
<i>Dependability</i>	34
<i>Conformability</i>	34
Ethical Considerations.....	35
<i>Voluntary Informed Consent</i>	35
<i>Confidentiality/Anonymity</i>	35
<i>Data Management</i>	36
Chapter 4: Findings	37
Participant Information.....	37
<i>Study Site</i>	37
<i>Study Sample</i>	38
Collaboration as a Concept.....	39
<i>What is collaboration?</i>	39
<i>Whom do you collaborate with?</i>	40
<i>Examples of Collaboration</i>	41
<i>Overall Experience of Collaboration</i>	42
Major Themes.....	44
Theme 1: Valuing PSWs' Contributions.....	45
Theme 2: Organizational Structure.....	48
<i>Management</i>	48
<i>Education</i>	49
<i>Scope of Practice</i>	50
<i>Time Constraints</i>	51
<i>Lack of Resources</i>	52

Theme 3: Individual Characteristics and Relationships	53
<i>Characteristics that Encourage Collaboration</i>	53
<i>Characteristics that Discourage Collaboration</i>	54
<i>Communication Skills</i>	55
<i>Quality of Relationships</i>	55
Summary	57
Chapter 5: Discussion & Conclusion.....	60
Discussion of Study Findings.....	61
<i>Theme 1</i>	61
<i>Theme 2</i>	63
<i>Theme 3</i>	65
Study Findings & The Structuration Model of Interprofessional Collaboration.....	67
Strengths & Limitations	70
Implications & Recommendations	71
<i>Education</i>	72
<i>Practice</i>	74
<i>Future Research</i>	78
Conclusion.....	80
References	83
Appendices.....	95
Appendix A: Long-Term Care Home Information Letter	95
Appendix B: Participant Information Letter & Consent Form.....	97
Appendix C: Interview Guide	101
Appendix D: Summary of Key Findings.....	103
Appendix E: Participant Follow-up Letter & Feedback Form	104
Appendix F: Ethics Approval Letter	106

Chapter One: Introduction

The segment of Canada's population that is 65 years and older is the fastest growing cohort in the country, and this cohort currently accounts for 16.1% of the total population, or 5.8 million people (Statistics Canada, 2015). In 2015, for the first time in Canadian history, the number of persons aged 65 years and older exceeded the number of children 0-14 years of age (Statistics Canada, 2015). By 2030, it is estimated that close to one in 4 people in Canada will be over the age of 65, accounting for 22.2 to 23.6% of the entire population (Statistics Canada, 2014). Looking specifically at Ontario, it is estimated that 4.1 million out of a projected population of 17.7 million will be over the age of 65 in 2036 (Statistics Canada, 2012). With the increasing number of older adults in both Canada and Ontario, the need for long-term care services is highlighted.

According to Statistics Canada (2011), there are approximately 225,000 individuals over the age of 65, or 4.5% of all seniors, currently living in long-term care in Canada. This number is likely to continue to grow as the population ages, with a projection of approximately 560,000-740,000 seniors requiring facility-based long-term care by the year 2031 (Canadian Health Association, 2009). The Long Term Care Innovation Expert Panel [LTCIEP] (2012) has defined long-term care homes, also referred to as nursing homes or homes for the aged in Canada, as facilities that are:

licensed by the Ontario Ministry of Health and Long Term Care ("the Ministry") that provides 24 hour nursing and personal care and services in a secure home-like setting for adults with assessed high needs who can no longer live independently in the community (p. 2).

In Ontario, there are currently 627 long-term care homes comprised of 76, 535 long-stay beds, which are approximately 99%, occupied (Ontario Long-Term Care Association [OLTCA], 2014). The OLTCA (2014) estimates that more than 100,000 seniors are cared for every year in these homes, with an additional 20,000 waiting upwards of 3 months for long-term care placement at any given time. The current demand for long-term care services in Ontario is likely to increase as the population ages, but it is also important to note that the level of care required to meet the needs of those in long-term care is likely to increase as well. According to the OLTCA (2013), long-term care homes in recent years have shifted from “primarily serving as residences for frail seniors to also providing medical care that was once only offered in hospitals such as advanced wound care, chemotherapy and dialysis” (p. 4). One report found that 83% of residents admitted to long-term care homes in 2010/11 had high or very high care needs compared to 72% in 2007/08 (Ontario Association of Community Care Access Centres [OACCAC], 2011), with another report suggesting that 93% of residents have two or more chronic conditions (OLTCA, 2014). Overall, long-term care homes are dealing with a more vulnerable population than five years ago and this translates to an increased demand on long-term care home staff and their need to adapt to ensure that safe, supportive and high quality care is being delivered consistently (OLTCA, 2014). Therefore, there is a need for continued focus on quality improvement, the clinical and administrative competencies of all practitioners, and the most efficient way to deliver care within these settings.

While long-term care in Canada is a provincial responsibility, which results in varied policy and planning specifications, as well as service characteristics, accessibility, and availability (Berta, Laporte, Zarnett, Valdmanis, & Anderson, 2006), one common

characteristic is the high proportion of personal support workers (PSWs) who deliver the majority of direct care to residents (Caspar & O'Rourke, 2008). In Canada, PSWs, also referred to as healthcare aides, nurses' aides, nursing assistants, unregulated care providers or unregulated health workers, provide 70-80% of direct care to residents living in long-term care homes, also known as nursing homes (Cranley et al., 2012; Janes, Sidani, Cott, & Rappolt, 2008; Kontos, Miller, Mitchell & Cott, 2011). Some studies suggest that this figure is in fact higher and represents 80-90% of all direct care (Caspar & O'Rourke, 2008). Personal support workers comprised approximately 72.3% of all frontline care staff working in long-term care homes in Ontario, while registered practical nurses and registered nurses comprised only 17.9% and 9.7% respectively (OLTCA, 2014).

Historically, PSWs have been an unregulated body of healthcare workers who lacked consistent educational preparation. While there have been efforts over the years to standardize training, particularly with the development of PSW program standards by the Ministry of Health in Ontario the mid-late 90s (Ontario Community Support Association [OCSA], 2009), the delay in implementation of these standards negated those efforts and further compounded the variability in available programs, resulting in diverse worker skill sets (Kelly & Bourgeault, 2015). At present, this remains largely the case, with PSW training being offered in numerous settings including "public colleges, for-profit private colleges, including some online and distance programs, by adult or continuing education programs offered through Ontario school boards, as well as training provided on-the-job" (Kelly & Bourgeault, 2015, p. 5). In July of 2014, the Ontario MTCU (2014) released a new PSW Program Standard in the hopes of ensuring that the varied educational options

for PSWs have similar outcomes in regards to skills; however, it remains unclear how PSWs who are currently working in long-term care will upgrade their education to meet these standards. Therefore, the variability in education, training and knowledge of PSWs' persists in long-term care.

According to the MTCU (2004), PSWs "work under the supervision of a regulated health professional or supervisor [...] and provide clearly identified personal care, routine activities of daily living, and home management services by following care/service plans and established policies and procedures" (p. 4). They also play a role in recognizing and reporting residents' symptoms that may require further intervention on the part of regulated staff members (Cranley et al., 2012). This form of care in long-term care homes is often described as intimate, personal, and both physically and emotionally challenging; however, through this daily, ongoing contact with the care recipient, a strong relationship often develops (Stone, 2001). Hence, this group of care providers are described as the "eyes and ears of the care system" (Stone, 2001, p. 49) and the "backbone of the long-term care industry" (Blair & Glaister, 2005, p.112). More recently, PSWs have been identified as key to resident quality of life (Morley, 2014).

Although PSWs are in contact with residents in the long-term care homes the most, approximately 2 hours per day, per resident (Sharkey, 2008), findings have indicated that their contributions to the resident care planning process are undervalued and often not acknowledged (Cranley et al., 2012). Decision-makers rarely consult PSWs (Blair & Glaister, 2005) in spite of their intimate knowledge and understanding of the resident's behaviors and individualized care requirements (Kontos, Miller, & Mitchell, 2010). Personal support workers want to be respected, want their knowledge to be taken

seriously, and want to be included in care planning meetings. This inclusion would give PSWs the opportunity to interact with the regulated healthcare professionals, as well as the family, and to let them know what steps are being taken to meet the social, physical and mental needs of the resident (Deutschman, 2001). According to Cranley et al. (2012), PSWs feel that they greatly contribute to residents' outcomes through their scope of practice, and therefore, wish to be asked for their opinions regarding the residents' plan of care.

The exclusion of PSWs from the care planning process has been attributed to a number of factors, specifically, low levels of interdisciplinary respect, communication, and collaboration between PSWs and nursing and medical practitioners (Kemper et al., 2008). Looking exclusively at collaboration with PSWs in long-term care, the literature is limited. The study conducted by Kontos et al. (2010) demonstrates that there is an acknowledgement among supervisors and nurses that PSWs "proximal and intimate relations with residents afforded unique and specialized knowledge of current functioning as well as first bedside awareness of therapeutic response" (p. 358); however, despite this belief, nurses often failed to solicit information from PSWs, and when the personal support worker initiated the exchange of clinical information, it was not met positively. Further, there appears to be poor interprofessional regard for the contributions of PSWs (Kontos et al., 2010).

Purpose of the Study

To date, there has been limited investigation on collaboration within the long-term care environment, which indicates the need for future research in this area in order to provide a more multifaceted view of the expectations, behaviours, and experiences of

collaborative practice in this setting (O'Brien, Martin, Heyworth & Meyer, 2009).

Therefore, the purpose of this study is to understand the personal support worker's experience of collaboration in long-term care facilities.

The study will address the following research question:

How do personal support workers describe their experience of collaboration in the long-term care home setting?

The next chapter will review the current literature to establish the movement of long-term care home culture towards a more person-centered care approach, how collaborative practice plays an important role in that care, and the way in which PSWs can contribute.

Chapter Two: Review of the Literature

The intent of this study is to develop a better understanding of personal support workers' (PSWs) experiences of collaboration in long-term care homes in Ontario. It is important to know and understand this phenomenon as PSWs play an integral role in the direct care of residents living in these homes and can provide unique and specialized knowledge of their care needs and preferences (Kontos et al., 2010). Each of the following will be discussed in this chapter to develop a better understanding of why the proposed study is necessary: the movement towards person-centered care, interprofessional collaboration and an accompanying conceptual framework, collaboration in long-term care homes, and PSWs' current and potential role in collaborative practice, as well as the benefits of their inclusion.

Movement Towards Person-Centered Care

The nursing home culture-change movement was born more than a decade ago (Rahman & Schenelle, 2008) as a result of a renewed focus on improving quality of life and quality of care problems that have plagued the long-term care industry (Flesner, 2009). There was a need to move away from the more traditional, institutional model of care that only addressed clinical needs towards a model that was characterized by elder choice and personalized services. This initiative was driven by a series of care models that conceptualized the structure, roles and processes of nursing home care to transform these homes from impersonal healthcare institutions into true person-centered homes offering long-term care services (Grabowski et al., 2014; Koren, 2010). The aim of person-centered care is to create caring communities where all parties, including frontline staff and residents, flourish and provide/receive the highest quality of care and of life

(Rahman & Schnelle, 2008). Person-centered care is established through the development of and support for relationships among all care providers, older people, their families and other people who are significant to them (McCormack & McCance, 2010; McGilton, Irwin-Robinson, Boscart & Spanjevic, 2012), with the mutual goal of creating routines for residents that are tailored to their life experiences and preferences (Koren, 2010). There is also a focus on improving the overall organizational culture of long-term care homes to enhance job satisfaction and care delivery processes (Roseman, Hanson, Enner, Schnek & Weiner, 2012). According to Koren (2010), in order for person-centered care to truly be successful in the long-term care sector, the following features must be present: resident direction, homelike atmosphere, close relationships, staff empowerment, collaborative decision-making, and quality improvement processes.

The person-centered approach to care in long-term care homes can result in outcomes “such as feeling appreciated as an individual, having something interesting to do during the day, experiencing moments that matter, honouring residents’ choices and preferences for daily living, maintaining important relationships and developing new relationships” (McGilton et al., 2012, p. 304). These outcomes can also include a higher satisfaction with care, increased involvement in care, an improved sense of well-being for the resident, and a more supportive therapeutic environment overall (McCormack & McCance, 2010). Researchers have also documented the value of allowing residents the right to make decisions for themselves, with those having more choice being more involved in activities, being happier and more alert (Flesner, 2009). In addition, a higher level of person-centered care has been shown to be correlated with residents’ having an overall higher quality of life and better ability to perform activities of daily living

(Sjorgen, Lindkvistm Sandman, Zingmark, & Edvardsson, 2013). Families have also identified the importance and need for care provided in accordance with the specific needs of residents (Sharkey, 2008).

Collaborative decision-making. If we accept the significance of person-centered care in achieving better quality of life for residents within long-term care, there needs to be a focus on the role and experiences of the care providers as well. Traditional, organizational structures often constrain the ability of staff to provide individualized, person-focused care and have often led to a lack of integration across members of the care team (Zimmerman, Shier & Saliba, 2014). Little evidence exists regarding the collaborative decision-making domain of successful culture change towards person-centered care as outlined by Koren (2010). A recent review of the literature examining current evidence relating to the efficacy of the culture change movement in long-term care only identified five articles, of the 36 retrieved, which looked at collaboration and collaborative decision-making among staff (Shier, Khodyakov, Cohen, Zimmerman, & Salbia, 2014), thus identifying a gap in the knowledge base. Therefore, the role and experiences of collaboration and collaborative practice within the current healthcare service delivery model in long-term care needs to be better understood in order to improve access to person-centered or resident-centered care.

Interprofessional Collaboration

Healthcare organizations, such as long-term care homes, are feeling the pressure to provide quality, timely, and person-centered services to patients and residents, and one way in which this care can be better facilitated is through collaboration and collaborative practice. The World Health Organization [WHO] (2010) defines collaborative practice in

health-care as occurring “when multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings” (p.13). It is important to note that the concept of health workers, in this definition, is considered

a wholly inclusive term, which refers to all people engaged in actions, whose primary intent is to enhance health. Included in this definition are those who promote and preserve health, those who diagnose and treat disease, health management and support workers, professionals with discrete/unique areas of competence, whether regulated or non-regulated, conventional or complementary (WHO, 2010, p. 13).

Additionally, Way, Jones and Busing (2000) highlight the importance of the inter-professional interaction within collaborative practice that enables the separate and shared knowledge and skills of all care providers to influence care. While a number of other definitions are available, a concept analysis of the term interdisciplinary collaboration, which was determined to be a surrogate concept for the terms collaborative practice and interprofessional collaboration, revealed that three attributes are consistently noted in the literature from nursing, medicine, and social work: a problem-focused process, sharing and working together (Petri, 2010). Through this concept analysis, it was also discovered that the consequences of collaboration were found to be largely positive in nature.

Specifically, these positive consequences were found to impact the resident, the organization, the system, and the healthcare professional (Petri, 2010).

HealthForceOntario (2007) furthers this by noting that interprofessional care can lead to many service improvements to patient (or resident) care delivery including but not

limited to: improved outcomes for people with chronic disease, less tension and conflict among caregivers, and better use of clinical resources.

The role of interprofessional care, which is a collaborative, team-based approach to providing optimal care, is not a new idea; however, it is becoming a more formally recognized approach to care delivery in a variety of settings (HealthForceOntario, 2007). Many work environments, however, struggle to determine the best method to support, implement and sustain this approach. More effective teamwork and communication amongst all staff groups is one way to address this and promote collaboration.

HealthForceOntario (2007), in the *Interprofessional Care: A Blueprint for Action in Ontario*, identified four overarching recommendations that if given adequate attention can provide an effective framework for interprofessional care. These include: building the foundation, which focuses on knowledge, skills, competencies and attitudes required to practice interprofessional care; sharing the responsibility; implementing systemic enablers, which will impact the ability to implement this approach to care; and leading sustainable cultural change, which centers on the notion of a strategy that is needed to target all levels of health care (HealthForceOntario, 2007). The Blueprint also acknowledges that all of those involved in health care have a role to play in interprofessional care and must be included in order for this approach to be successful (HealthForceOntario, 2007).

Interprofessional care can facilitate optimal care, person-centered care within the long-term care setting, therefore, it becomes increasingly important to understand the collaborative element of this approach to care in this setting.

Conceptual framework. The Structuration Model of Interprofessional Collaboration will be the framework used to guide this study. Developed by D'Amour, Sicotte, and Levy (1999), this model conceptualizes both interorganizational collaboration, but of particular interest here, interprofessional collaboration (D'Amour, Goulet, Labadie, San Martin-Rodriguez, & Pineault, 2008). The model's main objective is to examine collaborative processes, with a specific focus on collaboration between health professionals (D'Amour et al., 2008), and has been tested in a variety of settings including perinatal services (D'Amour, Goulet, Pineault, & Labadie, 2004), family health teams (Beaulieu et al., 2006), and integrated health networks (D'Amour et al., 2008). This model is appropriate to use in order to analyze how "complex and heterogeneous multi-level systems of actors collaborate" (D'Amour et al., 2008, p. 2), and makes it possible to "gauge the extent to which professionals are or are not focused on the interests of the patients" (D'Amour et al., 2008, p. 12). In this study, the framework will be utilized to inform the exploration of the individual, team, and organizational factors that influence the experiences of collaboration among PSWs in the long-term care setting.

This model is based on the concept of collective action, which was explored in Crozier and Friedberg's (1977) work on organizational sociology and organized action. Collective action is any organized action by a set of actors who are dependent on one another when working to solve, stabilize or structure a common problem, and who must navigate a formal set of rules and human relationships in order to be successful in achieving a common goal or purpose (Crozier & Friedberg, 1977). Collaboration, according to the authors, is the central element in any collective action or undertaking, and highlights healthcare professionals desire to work together to improve patient care,

while also maintaining their own interests, independence, and autonomy (D'Amour et al., 2008).

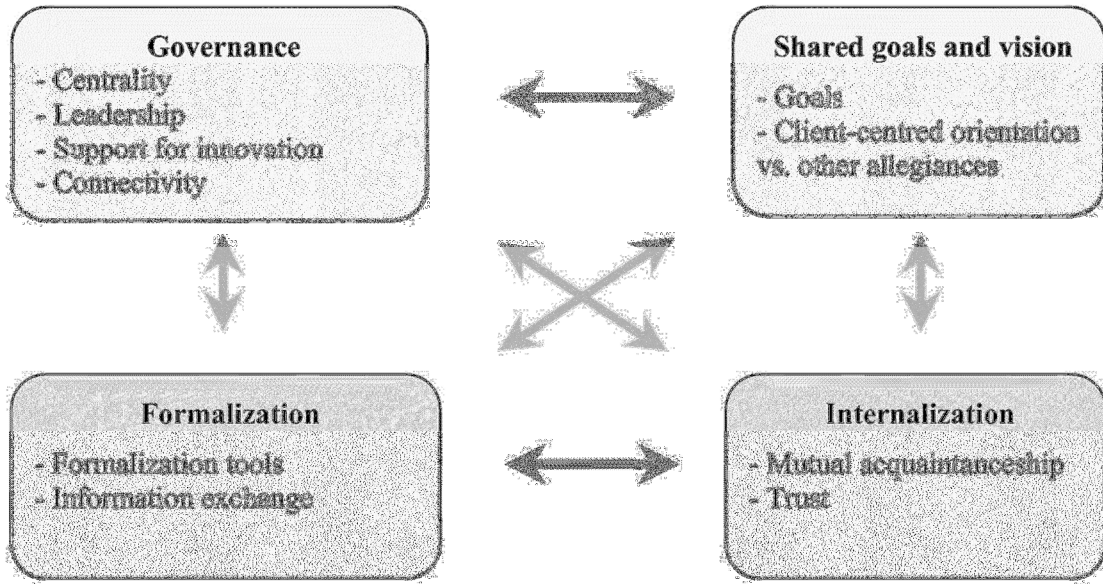


Figure 1. The Structuration Model of Collaboration. This figure illustrates the four dimensions of the model of collaboration and the ten indicators within these dimensions. The arrows indicate relationships and direction of influence between the dimensions.

The Structuration Model of Interprofessional Collaboration expands on Crozier and Friedberg's (1977) approach, and includes four dimensions within the collaborative process (D'Amour et al., 1999). These dimensions are not mutually exclusive, but rather are interrelated and influence one another. The relational dimensions include finalization and internalization, while the dimensions of formalization and governance involve the organizational setting. According to D'Amour et al. (2008) finalization involves a sharing and application of shared goals and vision, but also involves recognition of opposing motives and multiple allegiances, as well as an acknowledgment of differing definitions and expectations of collaboration within a healthcare team. Internalization, the second dimension discussed by D'Amour et al. (2008), implies a sense of belonging, but also

highlights the need for interdependency and the importance of managing these interdependencies. Relationships within teams are developed through mutual knowledge of each other's values and roles, and lead to a mutual trust. When looking at the organizational based dimensions, formalization, which is the structuring of clinical care, further clarifies expectations and responsibilities using rules and regulations within a system. Finally, governance includes supportive leadership functions that direct and support healthcare professionals as they implement innovations related to interprofessional collaborative practice (D'Amour et al., 2008).

When applying the Structuration Model of Interprofessional Collaboration (D'Amour et al., 1999) to this study, it is recognized that PSWs are part of the complex system. The model will contribute to the development of the questions for the semi-structured interview, as well as the codes and themes explored in the data analysis process.

Collaboration in Long-Term Care

The growing complexity of healthcare needs of residents necessitates professional interdependence in long-term care (D'Amour et al., 2005). Reeves et al. (2008) suggest that a number of factors, including an aging population and the shift of the burden of illness from acute to chronic care, require care providers from a number of disciplines (i.e. physicians, registered nurses, dieticians, physiotherapists) to work together to deliver the best possible care. Therefore, interprofessional collaboration needs to be fostered to better support quality care, as well as the overall goal of person-centered care. There needs to be a flattening of the typical long-term care home hierarchy and the

encouragement of a more participatory approach to care planning and decision-making (Koren, 2010).

Outcomes of collaboration in long-term care. The necessity for a collaborative team-based approach to resident care is rapidly becoming apparent in long-term care. Specifically, in a review of the literature, Zwarensten et al. (2004) found that collaborative practice in the area of geriatrics resulted in improved patient outcomes. Knowing the positive results that collaborative care provides, long-term care homes and their staff need to make more of an effort to include this type of practice in their facility. Collaboration regarding resident care occurs with some regularity in the long-term care setting. Two types of collaboration, in particular, have been well documented in the literature: with family (Davies & Nolan, 2006; Winn, Cook & Bonnel, 2004) and between physicians and nurses (American Medical Directors Association Ad Hoc Work Group on the Role of the Attending Physician and Advanced Practice Nurse, 2011; O'Brien et al., 2009). However, little evidence exists regarding the PSWs' role in and experiences of collaboration. Some studies have even suggested that nursing homes in Canada are not designed to facilitate collaborative care (Siegel et al., 2012) due to the delivery of care being directed from the top down (Barry, Brannon, & Mor, 2005; Colón-Emeric et al., 2007; Forbes-Thompson, Leiker, & Bleich, 2007), and the frequent omission of PSWs in care planning and decision-making (Colón-Emeric et al., 2006; Kontos et al., 2010). As discussed, collaboration is a key feature of successful person-centered care, and therefore, needs to be better understood, particularly from the perspective of the personal support worker, if we want to continue moving towards the highest quality of care.

PSWs in Collaborative Practice

PSWs are an essential part of the care delivery process within long-term care but studies have shown that their contributions to the resident care planning process are often not recognized within an organization (Caspar & O'Rourke, 2008; Cranley et al., 2012). There is growing evidence, however, that PSWs have the capacity to meaningfully contribute to the collaborative process. A study conducted by Cranley et al. (2012), which looked at engaging frontline staff in identifying resident care areas for quality improvement, showed a similarity in ranking between frontline staff and the 'other' group (registered nurses, care coordinators, managers and educators). In fact, the top five areas for a quality improvement intervention were the same for both groups (Cranley et al., 2012), demonstrating that PSWs often share common goals with regulated staff in long-term care homes. Further to this, PSWs have demonstrated their ability to engage in quality improvement initiatives at the bedside in a collaborative environment (Norton, Cranley, Cummings, & Estabrooks, 2013). Moreover, Fraser, O'Rourke, Baylon, Boström and Sales (2013), when looking at how PSWs perceive feedback reports on resident care practices in long-term care, found that 80% of participants understood the reports, while 69% believed that they would be useful for making changes to resident care. This study demonstrates the ability of this unregulated staff group to understand and utilize a resource currently used in long-term care among the regulated staff (Fraser et al., 2013). If this information was more readily accessible, or passed along, to the personal support worker, it would invite a more reciprocal flow of information regarding individualized patient care. Further, Corrazini, McConnell, Rapp and Anderson (2004) found that the formal inclusion of PSWs in the decision-making process regarding

patient/resident care led to improved outcomes in urinary incontinence. While these studies demonstrate the ability of PSWs to be involved in the collaborative process, the biggest supporting factors for their inclusion would be their proximity to the resident and their current relationship with the registered nurses in the home.

Proximity to residents. Residents consider PSWs paramount in their care as they often describe these individuals as considerate, experienced, and caring, while also making them feel as though they are not a forgotten person (Deutschman, 2001). Personal support workers spend the most time providing care for the residents, upwards of two hours per day per resident (Sharkey, 2008), and it is through these encounters that they 'get to know' the individuals as people, as opposed to residents. Kontos et al. (2010) found the proximity of PSWs' to residents increased familiarity, which allowed a better understanding of residents' biographical histories, such as trauma or marriage, which assisted PSWs in further tailoring the care they provided. Their intimate knowledge of residents' likes and dislikes has allowed them to find ways to anticipate and defuse challenging behavior and deal with unpleasant situations (Kontos et al., 2010; Snellgrove, Beck, Green & McSweeney, 2015). This proximity enables a personal support worker to "readily perceive [...] behaviors and responses and to alert RNs when changes develop" (Potter & Grant, 2004, p. 23). Personal support workers' knowledge of the resident as a result of this proximity can contribute to the overall ability to better meet a resident's needs. For this knowledge to be properly elicited, communication with other long-term care staff, in particular, registered nurses, must be effective and working relationships must be strong.

Staff Communication and Relationships

Communication is considered a binding factor in maintaining a strong nursing or long-term care home culture (Deutschman, 2001). Moreover, the transparent flow of information between staff and with residents within this setting is essential to provide the level of complex care often required by the residents (Forbes-Thompson et al., 2007). When communication is used effectively, the quality of person-centered care is often improved. For example, McGilton et al. (2006) evaluated a communication enhancement intervention in a complex continuing care facility and found that the use of strong communication practices, as a result of communication training, encouraged staff to ask patients about their feelings, hopes and desires. This led to the staff being better informed of their residents' preferences, which is a main tenant of person-centered care (McGilton et al., 2006). While resident-caregiver communication is important, a strong communication practice between staff members is as well. Wagner, Damianakis, Mafriqi and Robinson-Holt's (2010) study on falls communication patterns among nursing staff in long-term care highlights the importance of ongoing staff dialogue in identifying risk factors for residents within the home to prevent the occurrence of an adverse event. This study, however, also underlines the existing communication tension and hostility, as well as a lack of overall communication, between licensed and unlicensed staff members (Wagner et al., 2010). Recent nursing home studies that have explored communication support this and document concerns about communication openness, accuracy, and timeliness among different members of the staff and staff levels (Anderson et al., 2005; Scott-Cawiezell et al., 2004; 2005; Wagner et al., 2010). Ways in which this

communication can be improved need to be further explored, and a closer look at relationships is needed.

Good communication often results from a strong working relationship, and managers know that the quality of care delivered to patients and residents can be affected by the type of working relationship that exists between staff (Potter & Grant, 2004). Understanding these relationships, and how they are developed and maintained, is the basis for high-quality care (Anderson et al., 2005). Broader contextual factors may impede the ability to have effective working relationships within these homes as PSWs have little autonomy, and consistently state that they want their contributions to be recognized by regulated staff and to be included in the care planning and care conferences (Deutschman, 2001). Further, they reported that they do not consistently feel respected by their supervisors and are not given the opportunity to inform and thus influence the type of care that they provide (Caspar & O'Rourke, 2008). Caspar and O'Rourke (2008) assert that this perceived lack of a reciprocal relationship has a direct influence on the ability of PSWs to provide individualized care. This breakdown in the working relationship between licensed and unlicensed staff leads to a lack of initiative, poor communication and collaboration, which results in a lack of teamwork and inefficiency in delivering care (Potter & Grant, 2004). According to Colón-Emeric et al. (2006), to improve the flow of information and the working relationship with PSWs, there is a need to move away from a closed, vertical method of communication to one that is more horizontal, open and positive. Moreover, by respecting and supporting the decision making role of frontline caregivers, or PSWs, , there is an assurance that the rights and preferences of residents regarding their care are respected too (Rader &

Semradek, 2003). Arguably, one of the most important relationships within this setting is that between the nurse and the PSW.

Nurse/personal support worker relationship. Due to the staffing model in long-term care homes, nurses have larger workloads and a limited amount of time to spend with each resident (Fewster-Thuente & Velsor-Friedrich, 2008). Therefore, PSWs are providing a great deal of resident care that was previously rendered by nurses, and their knowledge needs to be recognized. Personal support workers keep registered nurses informed regarding how care is progressing and how residents are responding (Potter & Grant, 2004). Person-centered care requires nurses to be familiar with the residents, and this familiarity often results from working through others in an indirect role (McGilton et al., 2012). McGilton et al. (2012) further this by noting that registered nurses work through PSWs:

to ensure that interventions as prescribed are delivered and to evaluate their effectiveness. As many residents are unpredictable and vulnerable to changes in their environment, modifying plans of care to ensure resident's needs are met are a vital component of the RNs role (p. 21).

Although the PSWs are the practitioners most likely to observe, interpret and respond to these care plans (Anderson et al., 2005), their input is often not sought when care decisions are being made or implemented (Blair & Glaister, 2005; Caspar & O'Rourke, 2008). The informal structure for collaboration on care planning already exists between registered nurses and PSWs because they communicate about the resident regularly; however, two way communication needs to play a larger role with the personal support worker informing the nurse, and the nurse consulting the personal support worker (Potter

& Grant, 2004). According to Potter and Grant (2004), when an experienced registered nurse and personal support worker “work together to deliver patient care, the combined knowledge and experience [...] can be invaluable in recognizing patient’s clinical needs, adapting interventions for greater efficacy, and achieving positive patient outcomes” (p. 23). Therefore, the presence of an effective and collaborative registered nurse-personal support worker relationship must be attained for efficient, individualized care to be delivered to a resident.

Staff empowerment. Having access to information, support from other healthcare team members, resources and opportunities can motivate an individual to attain organizational goals (Caspar & O’Rourke, 2008). In long-term care, this organizational goal would be the one previously described as person-centered care (McGilton et al., 2012). By understanding and empowering PSWs, it enables them to have a better sense of control over their work environment, and this sense of control has been shown to foster productivity and improved organizational effectiveness (Barry, Brannon, & Mor, 2005). In the study conducted by Barry et al. (2005), there was a strong correlation between the amount of personal support worker influence on care decisions and the residents’ subsequent engagement in the life of the home. PSWs, who provide the most hands-on-care, have unique knowledge about the resident’s likes and dislikes, and this knowledge communicated to other staff results in better, more individualized care (Barry et al., 2005). The study conducted by Caspar and O’Rourke (2008) found a similar result in that access to structural empowerment has a statistically significant positive influence on reported provision of individualized care. By providing the personal support worker with a more meaningful opportunity to contribute to the care planning process, a direct

positive patient/resident outcome was observed. One way to achieve this is through more collaborative practice.

Summary

Almost and Laschinger (2002) contend that: "Lack of collaboration can lead to fragmentation of care, patient dissatisfaction, and poor outcomes. In addition, non-collaborative work environments may contribute to role dissatisfaction and job strain for healthcare professionals responsible for ensuring high quality care" (p. 410). Therefore, it is important that a more collaborative, less hierarchal approach between PSWs, or unregulated care providers, and regulated care providers be developed and understood. With PSWs being the primary resource in the long-term care setting (Blair & Glaister, 2005), and providing the most direct care to the resident (Caspar & O'Rourke, 2008; Cranley et al., 2012; Sharkey, 2008), it is vital that their potential contributions to a more collaborative, person-centered practice be acknowledged. Observers have stressed that PSWs must be engaged in adapting and implementing resident centered care in order for it to be successful (Yeatts & Cready, 2007). Fraser et al. (2013) believe that "further engaging [PSWs] in knowledge sharing and decision-making is important. ... Including and even targeting this group of providers may result in important advances in improving the quality of resident care" (p. 8). Therefore, by gaining a better understanding of PSWs' current experiences with collaboration in long-term care, while also learning what barriers and facilitators to this collaboration exist, it is the hope that person-centered care can be improved.

Chapter Three: Methodology

This chapter provides an overview of the methodology of the study, specifically, the qualitative approach, data collection, data analysis, trustworthiness and authenticity, and ethical considerations.

Qualitative research, specifically, is focused on a detailed, in-depth description and understanding of a concept, phenomenon, or experience that occurs within society (Patton, 2002). It aims to understand, describe and interpret social phenomena as perceived by individuals, groups and cultures, while adopting a person-centered and holistic perspective (Holloway & Wheeler, 2010). Qualitative research is conducted when a desired level of detail “can only be established by talking directly with people, going to their homes or places of work, and allowing them to tell their stories unencumbered by what we expect to find or what we have read in the literature” (Creswell, 2013, p. 48). It is particularly suited for why, how and what questions, and according to Creswell (2013) and Patton (2002), the importance of the research question matching the method cannot be overstated. Therefore, adopting a qualitative approach for the present study is fitting given the study’s focus on describing how PSWs experience collaboration within long-term care homes.

Qualitative Description

Qualitative description, as a methodological approach within the qualitative research domain, seeks to provide a comprehensive summary or description of an event or an individual’s experience in a language that is similar to his or her own. The goal of this method is to develop a rich, straight description of the event or experience of interest (Neergaard, Olesen, Andersen, & Sondergaard, 2009; Sandelowski, 2000). This method

of inquiry is often considered the “least theoretical of the spectrum of qualitative approaches” (Sandelowski, 2000, p. 337) because qualitative descriptive studies are largely founded on existing knowledge and previous works (Neergaard et al., 2009), not pre-determined theoretical or philosophical commitments (Sandelowski, 2000). However, it is important to note that qualitative descriptive studies are not atheoretical as they do draw on the general principles of naturalistic inquiry, which purports a commitment to studying something in a natural state (Sandelowski, 2010). Thus, “there is no pre-selection of variables to study, no manipulation of variables, and no a priori commitment to any one theoretical view of a target phenomenon” (Sandelowski, 2000, p. 377). These studies, however, can start with a theory of the target phenomenon, but there is no requirement to stay with it. And it is this theoretical and philosophical freedom, with no pre-existing set of rules to which to adhere, that allows for qualitative descriptive studies to stay close to the data and produce results that are purely inductive and data-driven (Neergaard et al., 2009; Sandelowski, 2000). Researchers, then, can accurately describe all of the elements that come together to make an experience what it is (Sandelowski, 2000). Thus, qualitative descriptive is the design of choice as this study’s research question seeks a straightforward description of a particular experience from the perspectives of the participant.

Reflexivity/Role of the researcher. While the qualitative descriptive method is considered less interpretive than other qualitative approaches such as phenomenology, no description is completely free of interpretation as the researcher selects the variables to study and to draw conclusions from (Sandelowski, 2000; 2010). The researcher, in attempting to describe an experience, will choose which aspects to feature, thus

beginning to transform it based on their own perceptions, inclinations and sensitivities (Sandelowski, 2000). Therefore, reflexivity requires the researcher “to be critically conscious through personal accounting of how the researcher’s self-location, position, and interests influence all stages of the research process” (Pillow, 2003, p.178).

My interest in conducting this study stems from both an awareness of the growing number of older adults, 65 years and older, who are currently living in long-term care homes, as well as the number who will require long-term care placement in the coming years (CHA, 2009). Moreover, through my work at the Nursing Best Practice Research Unit in Ottawa, ON, I was able to interact with a variety of long-term care home staff members through our research on practice change in this setting (Murray, Smith, Edwards, Greenough, & Hoogeveen, 2011). While this research focused on the feedback component of the decision-making process in long-term care, the importance of engagement of front-line staff, which includes personal support workers (PSWs), was highlighted when the formal focus group discussion ended. It was through these informal conversations that I began to consider the role that PSWs could play in collaborative practice and decision-making to improve overall quality of resident care.

There is some resistance, however, to increasing the PSW’s role in collaboration (Caspar & O’Rourke, 2008), so I believe that it is important to determine their current experiences with collaboration and to explore what factors facilitate/hinder this process. This knowledge could help in determining what skills and interventions need to be implemented to promote collaborative practice with PSWs. Additionally, this understanding would assist in developing ways to more efficiently use PSWs’ knowledge

of the resident to improve person-centered care. In order to develop this understanding, semi-structured interviews were employed.

Sample Size and Participant Selection

Sample size. The selection of the sample has a profound effect on the ultimate quality of the research, and arguably, is contingent on both the appropriateness of the sample and the richness of the data obtained (Sandelowski, 1995). Given the focus of the study on being able to provide a detailed description of an experience, it is vital that all participants have lived through this experience in order to provide an information-rich case. Therefore, a criterion sampling strategy, a form of purposeful sampling whereby sampling decisions are made based on individual characteristics, was employed. This sampling strategy was appropriate given the chosen method because purposeful sampling is the most commonly used sampling strategy in qualitative descriptive studies (Neergaard et al., 2009; Sandelowski, 2000). A sample size of 8-10 participants was desired for this study. Eight participants were successfully recruited, and the researcher determined that the eight interviews provided sufficient details to develop a rich description of the experience and did not recruit any additional participants.

Participant selection. Participants were recruited from a small long-term care facility located in rural Ontario. This facility fits the three broad components of accommodation, hospitality services, and health services that define long-term care according to the Canadian Health Association (2009). As with all long-term care homes in Ontario, this facility is regulated by the Ontario Long-Term Care Act (2007). In order to elicit a description of the experience being studied, it was important to have participants who have lived the experience and were willing to talk about it

(Sandelowski, 2000). Therefore, to be included in the study, a participant must (a) have been working as a personal support worker with at least one-year experience; (b) be currently working in the designated long-term care home; and (c) be currently working in a long-term care home in rural Ontario.

Gaining entry. Prior to recruiting the participants, access to the selected long-term care facility had to be granted. A letter of information (Appendix A) which outlined the study's purpose and procedures was sent to long-term care homes' Chief Executive Officer (CEO) by e-mail for review. In the response to this email, the CEO provided permission for the study to be conducted in the long-term care home. This e-mail also connected the student investigator with the Chief Research Officer (CRO), who followed up with a formal letter of permission and also arranged a time to attend a staff meeting for recruitment.

Recruitment. Upon receiving permission from the long-term care home's administration via the aforementioned letter, the student investigator attended a staff meeting to recruit potential participants. Following a short presentation to the staff, a letter of information and informed consent form (Appendix B) was provided to all of the PSWs in attendance. This invitation included the contact information for the study investigator so that participants could directly contact the investigator for more information and to discuss method and time/date of interview.

Recruitment at the staff meeting resulted in just two individuals agreeing to participate; therefore, the investigator visited the long-term care home on two other occasions where less formal presentations were given in the PSWs' break room. This secondary approach was used after concern was raised that the PSWs associated the

project with management (due to the venue of the initial presentation where management was present) and were hesitant to participate due to negative experiences. Connecting with the PSWs in a less formal setting proved a better approach because six additional individuals agreed to participate through contact made outside of this meeting. All eight participants met the inclusion criteria of the study and were successfully recruited from the long-term care home. Therefore, a second long-term care home was not approached regarding recruitment. The eight participants were provided a letter of information and consent form (Appendix B), regardless of when and what venue within the home they were recruited. They were asked to review, sign and return the consent form prior to the interview. However, several participants were not able to return the hardcopy due to their choice to connect via telephone, and therefore, participants were able to give verbal consent.

Data Collection

For purposes of this study, data was collected via digitally recorded moderately structured interviews conducted with the identified participants as congruent with qualitative descriptive methods (Neergaard et al., 2009; Sandelowski, 2000). These moderately structured interviews were “directed toward discovering the who, what, and where of events or experiences, or their basic nature and shape” (Sandelowski, 2000, p. 338). Specifically, the format ensured that information was elicited that pertained to the topic of interest, while also allowing for the topic to be explored more openly with the individual’s ideas and opinions being expressed in their own words (Holloway & Wheeler, 2010). Six questions were used to guide the interview (Appendix C) and additional prompts were used to clarify questions and encourage continued discussion.

The length of time for each interview varied based on the participant, ranging from 12-37 minutes in length. Prior to the interview commencing, several demographic questions were posed to the interviewee in order to gather additional details about the study sample. Participants were given the choice of a face-to-face interview or via telephone. Telephone was the preferred method, with 7 of 8 participants requesting to be contacted this way. In qualitative research, telephone interviews are often seen as a less attractive alternative to face-to-face; however, Novick (2008), in a review of the literature, found that “although loss of rapport, inability to probe, or deception via telephone may be thought to result in loss of or distortion of verbal data, there is no evidence that these problems arise” (p. 8). Each recording was transcribed verbatim by the researcher to provide a text for analysis with pseudonyms used for any identifying features mentioned in the interviews.

Data Analysis

Data analysis in qualitative research “involves reducing the volume of raw information, sifting trivia from significance, identifying significant patterns, and constructing a framework for communicating [what] the data reveals” (Patton, 2002, p. 432). Specifically, for qualitative descriptive studies, the aim is to discover the nature of the specific event under study by staying near the surface of the words. Thus, a data analysis method, such as content or thematic analysis, which is considered low-inference, is ideal (Sandelowski, 2000; 2010).

Thematic analysis. The analytic approach used in this study was that of a thematic analysis, “a method for identifying, analyzing, and reporting patterns (themes) within data. It minimally organizes and describes your data set” (Braun & Clarke, 2006, p. 79). Thematic analysis is flexible and independent of theory, and it is this flexibility

and theoretical freedom that allows for a rich, detailed, while still complex, account of the data: it works to reflect reality (Braun & Clarke, 2006). The analysis took an inductive approach, indicating that the themes and codes were data-derived. For organization and categorical purposes, all of the data was coded in the qualitative data software program NVivo. The following outlines the steps of the thematic analysis process, as described by Braun and Clarke (2006) that were used to guide the analysis of this study:

- 1) *Familiarising with data*: This step involved transcribing, reading, and rereading the data. This immersion in the data allowed for a better understanding of the depth and breadth of the content. The entire data set was reviewed prior to the generation of codes; however, initial thoughts were noted to refer to in subsequent steps (Braun & Clark, 2006).
- 2) *Generating initial codes*: After the initial review of the data, codes, which identified an interesting feature of the data, were developed. These codes were systematically applied to the entire dataset, giving particular attention to collating data relevant to each potential theme (Braun & Clarke, 2006).
- 3) *Searching for themes*: This phase involved analysis at the broader level of themes, rather than codes. The codes were reviewed to determine how they could be combined into larger, overarching themes. Main themes and sub-themes were then created (Braun & Clarke 2006).
- 4) *Reviewing themes*: The refinement of themes began in this phase by checking to see how the themes worked in relation to the coded extracts and entire dataset. At this point, in conjunction with the thesis supervisor, themes were

created, discarded or collapsed based on how the data fit (Braun & Clarke, 2006).

- 5) *Defining and naming themes*: In this phase, continued analysis further refined each theme in order to better understand the essence of the theme and what aspects of the data the theme captured. A clear definition of each theme, along with a name, was produced at this phase (Braun & Clarke, 2006).
- 6) *Producing the report*: Once the themes were fully worked-out, a report was created that “provide[d] a concise, coherent, logical, non-repetitive and interesting account of the story that the data tell – within and across themes” (Braun & Clarke, 2006, p. 93). Vivid and compelling examples were extracted to provide evidence of the themes. Overall, “a descriptive summary of the informational contents of data organized in a way that best fits the data” (Sandelowski, 2000) was created.

Trustworthiness and Authenticity

All research is open to scrutiny from its readers, regardless of the type of inquiry, the methodological approach used, or the specific methods that were employed. Both qualitative and quantitative research strive to be as rigorous as possible, but it is important to recognize that qualitative research should not be evaluated against the same set of criteria as quantitative research because the nature and purpose of the two traditions are different (Krefting, 1991). In qualitative research, the term trustworthiness is generally used in place of rigour and promotes thoroughness and competence, while creating evocative, true to life and meaningful portraits, stories and landscapes of human experience (Holloway & Wheeler, 2010). The terms validity, generalizability, reliability

and objectivity address the core concepts of truth-value, applicability, consistency and neutrality presented in Krefting's (1991) article on rigor in qualitative research. However these same concepts within the naturalistic, interpretive paradigm are restructured as credibility, transferability, dependability and confirmability (Holloway & Wheeler, 2010; Lincoln & Guba, 1985). The following section describes how each of these elements was achieved and maintained in the study.

Credibility. According to Lincoln and Guba (1985), credibility is the discovery of human experiences as they are lived and perceived by the informants, and it is the researcher's job to ensure that the multiple realities of the informants are adequately represented (Krefting, 1991). To ensure the compatibility between researcher's findings and the perceptions of those under study, several steps were completed:

- 1) *Peer debriefing.* Peer debriefing occurs when colleagues of the researcher who are competent in qualitative research procedures re-analyze the data, listen to the researcher's concerns, and discuss them (Lincoln & Guba, 1985). As a Master's student, this was accomplished via meetings with the thesis supervisor.
- 2) *Progressive subjectivity/reflexivity.* A journal was kept throughout the research process to capture information pertaining to the daily schedule and logistics of the study, all decisions pertaining to the methods used, as well as thoughts, feelings and ideas that have arose (Lincoln & Guba, 1985). In addition, this was a place to record notes about what questions or probes were effective in previous interviews and could be utilized in upcoming interviews and initial thoughts on codes and themes. This

journal is not a piece of data, and therefore, was not analyzed. It simply allowed the research to be auditable (Krefting, 1991).

- 3) *Member checking.* To ensure credibility, it is important that informants recognize their own experiences in the research findings; therefore, it is vital that researchers check with the informants that their interpretation is a true and fair representation of what was discussed (Lincoln & Guba, 1985). For purposes of this study, member checks were accomplished by giving the participants a summary of the key themes elicited from this study (Appendix D), with the caveat that the summary represents multiple realities not their own individual reality. These summaries were sent to the participants in the method of their choice, either e-mail or mail, which was determined during the initial conversation. They were given a form (Appendix E) on which they could provide feedback regarding these themes if they wished to do so. They were given a two-week turnaround time to return the form, with no response indicating they had no comments or concerns about what was presented. No completed feedback forms were received.
- 4) *Data Saturation.* Eight participants were recruited for this study, which was the desired sample size. No additional participants were recruited as data saturation had been achieved which was made evident by no new relevant information, particularly in regards to barriers or facilitators, being introduced.

Transferability. The term transferability is used instead of generalizability to refer to the degree to which findings can be transferred to similar situations or participants. The knowledge acquired in one context will be relevant in another and certain concepts developed in the original research can be applied (Lincoln & Guba, 1985). The research meets this criterion when sufficient descriptive data has been collected that would allow for comparison (Lincoln & Guba, 1985). This was achieved due to the description of the experience that was elicited via the interviews. According to Holloway and Wheeler (2010), if the

contextual description is rich and the analytical language comprehensive enough to enable readers to understand the processes and interactions involved, it might be possible to generalize to the extent of stating that people in other settings have a similar way of understanding (p. 310-11).

Dependability. Variability is not only expected in qualitative research, but it is desired as this emphasizes the uniqueness of the human experience (Krefting, 1991). Consistency, in this tradition, is measured by dependability, which simply implies trackable variability or variability that can be ascribed to an identified source (Lincoln & Guba, 1985). This was achieved by maintaining an audit trail or “a detailed record of the decisions made before and during the research and a description of the research process” (Holloway & Wheeler, 2010, p. 310). This audit trail was captured in the progressive/subjectivity journal that was described in detail in this? section.

Confirmability. The last criterion, confirmability, speaks to the notion of maintaining an awareness of where you, as the researcher, are situated in the research, and what measures are being taken to ensure reflexivity throughout the process

(Holloway & Wheeler, 2010). Reflexivity promotes and ensures confirmability, and as described in detail earlier, is being used by the researcher in this study.

Ethical Considerations

The research was conducted in accordance with the standards of the Tri-Council Policy Statement for Ethical Conduct for Research Involving Humans (CIHR, NSERC, SSHRC). Approval from Brock University's Research Ethics Board was granted on October 16th, 2014, prior to the commencement of the study (Appendix F). The long-term care home in the study did not have a formal ethics board; however, a formal letter of permission/support was provided on October 31st, 2014 after the project details were reviewed by the CEO and CRO. A number of ethical issues were considered in conducting this research and are outlined below.

Voluntary informed consent. All participants received an in-depth explanation of the scope of the research prior to agreeing to participate. If the participant agreed to participate in the study, the participant was asked to sign the consent form (see Appendix B). This consent form outlined the details and the scope of the research, their role of the participant in the research process, and the participants' right to withdraw from the study at any time.

Anonymity and confidentiality. Participation in this study was anonymous. Each participant was given a number and only the researcher was able to access the list, which allowed for the participant number to be matched to the participant name. This list was kept in a locked filing cabinet at the researcher's home. These participant numbers were used in all transcribed data. In addition, any other identifying information, such as institution names or the names of other colleagues were given pseudonyms, and recorded

elsewhere, as well. Confidentiality could not be guaranteed as quotations and codes extracted from the data were utilized to support the themes presented in the report.

Data management. All data gathered during the research process was stored at the home of the primary researcher, as this was where analysis took place. All electronic files, specifically, the transcripts, were saved in password-protected document format on the researcher's laptop until the end of the study, at which time they were transferred to a password-protected USB key and are maintained in a locked filing cabinet at the investigators residence. This data will be kept for a period of 7 years, at which point it will be destroyed with all hardcopies of files being shredded and e-files being deleted. The only people who will have access to this data will be the researcher, the supervisor, and the thesis committee. No copies of the digitally recorded interviews or corresponding transcripts were made.

Chapter Four: Findings

In this chapter, the findings are presented in three sections. In the first section, a description of the study site, as well as the study participants, is presented to provide a background for the study. The second section provides a definition of the term collaboration as described and defined by the study participants. And finally, the third section presents themes that emerged in response to the study's research question, "How do personal support workers (PSWs) describe their experience of collaboration in the long-term care home setting?" The question revealed three major themes: valuing personal support workers contributions, organizational structure, and individual characteristics and relationships.

Participant Information

Study Site. All eight participants were sampled from one long-term care facility located in rural Ontario that has less than 100 licensed beds.

This facility has undergone some significant changes in regards to structure and management in recent years. It was owned and operated by the same group of individuals for over three decades who exemplified a long-standing tradition of excellence in long-term care services. The owners, who also acted as the management in this facility, developed strong relationships with not only the residents and their families, but also with the front line staff who had worked there for the majority of their careers. The study participants described the owners as both personable and approachable, and as having a strong rapport with staff; however, approximately 4 years ago, the facility was sold. And while this new ownership has continued to dedicate itself to providing high quality care and to supporting the residents, staff and community, the change has been challenging for

some PSWs who were accustomed to the old management and the old way of doing things. Several PSWs expressed that consistency in the facility has been somewhat lacking, and that roles, responsibilities, and expectations, which they feel differ from the previous owners, are not always clear. In addition to the ownership changes, new policies set forth by Ontario's Ministry of Health and Long-Term Care (MOHLTC), specifically the Long-Term Care Home Quality Inspection Program, have led to increased Ministry visits in the past 6-8 months in all long-term care homes in the province. The "MOHLTC conducts complaint, critical incident, follow up, comprehensive and other types of inspections" (MOHLTC, 2015, para. 2) within the home. According to the PSWs in this study, these inspections are often unannounced and have led to increased pressure on the facility staff. Therefore, both the ownership changes in recent years and the increased scrutiny by the Ministry in recent months have led to a more stressful work environment.

Study Sample. Eight PSWs agreed to participate in the study. All of the participants in the study were female, aligning with the observation that this is a largely female-dominated profession. Six of the participants were full-time employees of the home, while two were working part-time. Interestingly, both of the part-time employees indicated that they are part-time in status only but often work full-time equivalent hours because they cover other employees' sick leave and holidays. Their ages spanned three decades, with the following breakdown by age category: three participants were 30-39, two were 40-49, two were 50-59, and one participant was over the age of 60. All of the participants had successfully completed a PSW training course, with some having taken the course prior to starting in the profession and others having had work experience before returning to the classroom for formal training. Due to recent changes in the Long-

Term Care Act (2007) and the development of the PSW Program Standard (MCTU, 2014), there is now a minimum education standard for PSWs. This standard, however, has not yet led to the development of a standard curriculum for PSW training, and therefore, it is important to note that there remains variability amongst the PSWs' training based on when and where they have taken a course (Kelly & Bourgeault, 2015). Two of the participants are currently working on continuing education ventures. While the level of education amongst the group varied, all of the participants had a minimum of 10 years' experience as a PSW. The average number of years working as a PSW for the participants was 20.3 years, with three of the participants having over 30 years on the job. The variation in age, education, and years of experience amongst the participants proved important in this study as it allowed for different perspectives on collaboration.

Collaboration as a Concept

This section explores the PSWs' understanding of the concept of collaboration; more specifically, how they define it, who they identify as potential collaborators, how they see the process of collaboration occurring in their day-to-day practice, and their overall experience of collaboration.

What is collaboration? In order to support the overall aim of developing a description of how PSWs' experience collaboration in long-term care, it was important to determine their understanding of the concept and how they see collaboration working in the LTC home. Based on the participants' responses to the question "*How do you define collaboration?*" the following definition was developed:

Collaboration is a group of people working together to achieve the shared goal of delivering the best possible care to residents.

While the *shared goal of delivering the best possible care* to residents was stated by the majority of the participants in this study, the element of this definition that was the most significant to all eight participants was that of *working together*. The PSWs in this study centered their understanding of the concept of collaboration around the idea of working together as a team and being involved in teamwork. This was particularly evident throughout all of the interviews because they used the concept of working together or teamwork interchangeably with or in place of collaboration and the collaborative process. Two elements of this developed definition, *working together* and having a *shared goal*, appear in many commonly used definitions of collaboration; however, *delivering the best possible care to the residents* is more context-specific and is an outcome of collaboration that is more relevant to healthcare workers, including PSWs.

While all of the PSWs were able to provide some level of a definition for the concept of collaboration, the responses to that question were not always made confidently. There was evidence of hesitation or confusion in some of their voices, with several participants asking if the definition they provided was okay, correct or what was required of them. Also, one of participants indicated that prior to the presentation to the PSWs for the purposes of recruitment, they would have never used the term collaboration and that their understanding of the term stemmed from what was shared that day. Thus, while a definition was able to be developed based on the participants responses, there was evidence of some lack of understanding of the concept overall.

With whom do you collaborate? While all healthcare providers are encouraged to collaborate with one another in healthcare settings, according the study participants, that is not always the case. When asking the participants who they collaborate with the

most, it appeared that intradisciplinary collaboration was occurring most frequently, meaning, PSWs were collaborating most often and most effectively with other PSWs who share their scope of practice. In addition, there was evidence of collaboration between the PSWs and other registered staff. While registered staff encompassed both RNs and RPNs, there was more discussion of RPNs working with PSWs to deliver care than RNs. The participants also indicated some instances of collaborating with other departments in the home including dietary, laundry and activities. There were also references made to collaborating with community groups that come into the home, the residents' families, and the residents themselves. Interestingly, only one participant mentioned collaborating with the home's management, with the general sentiment around collaborating with management being largely negative and not happening. Also, PSWs do not have the opportunity to collaborate or work with physicians or physiotherapists according to one study participant.

Examples of collaboration. In addition to defining the term and discussing with whom they collaborate, the participants were asked to provide an example of a time they have collaborated in their work. In doing so, it allowed for a better sense of their understanding of the concept but also to determine why they engage in collaboration and the desired outcomes. In reviewing the responses to this query, it becomes clear that all of the examples of collaboration provided by the participants are either problem-driven, where they have had to work with others to identify the problem, or solution-driven, where they already know what the problem is but need to work with others to identify a solution. For instance, Participant 8 provided an example of a time that she collaborated in her work that was problem-driven:

Umm, it was a little while ago, but we had a resident that was pretty restless at night and I couldn't figure out why. I gave her an extra blanket, she still wouldn't settle. Um, so, ya, I remember asking a few people what was up. So, and one of them told me likes being tucked in, you know what I mean? Umm, ya, so I tried that the next night shift I was on, and it worked.

While this example involves the participant seeking information from others in order to identify a problem, some participants viewed collaboration as more of a solution-driven process. This is evidenced by the following example:

When I feel that a resident needs an air mattress, I'll talk with the RPN and together we'll address the management, and say, you know, we've looked at the situation and are checking out the skin integrity, and we really believe that ... so you, we, we team up when we seeing something that we think can be improved on (Participant 2).

The examples provided here, as well as the other responses, give support to the definition of collaboration developed for this study as the examples all demonstrate some level of individuals working together to deliver the best possible care to the residents.

Overall Experience of Collaboration. When asked the question of '*How would you describe your experience of collaboration?*' the PSWs presented a very broad picture of what is occurring in the practice setting. A few of the respondents felt that collaboration was happening in the home and was an overall positive experience. As described by one participant, each individual in the home plays a role, which allows for a collaborative care delivery process:

If I have issues or problems with the resident as far as health or health concerns, it's very much collaborative. I can go to them [RNs] and we can discuss together. But with the actual hands-on care, uh, its all in my opinion, PSWs. The nurse is the thinker, but the PSW is the hands-on person [...] I think its positive, I think it happens (Participant 2).

Other participants had more mixed feelings about collaboration and their current experiences of it. They felt it was more difficult than easy. And while they acknowledge

that collaboration does occur, it is not a regular part of their practice within the home.

One participant describes her experience of collaboration below:

Well, I don't know if it necessarily happens as often as it should. Maybe. [pause]. I think it does happen from time to time, like there is teamwork, but not enough maybe, but they don't always listen. Um, so I guess my experience would be good and bad (Participant 8).

In contrast, several participants painted their current experience of collaboration in the home much more negatively, indicating that it is difficult, frustrating and overall, not occurring. This is evidenced by comments such as:

You are just expected to get along, but it doesn't work that way. Nobody gets along, there's no harmony. I guess that makes this whole idea of working together or collaboration so tough. I think it's lacking (Participant 5).

I would say there is very little collaboration or whatever you want to call it (Participant 6).

Their negative experience of collaboration within the home also seemed to be influenced by the general lack of follow through when a collaborative process had been started. Several participants highlighted that this lack of follow through discourages them from continuing to try to be involved and work with others, with one participant stating:

I find there's a lack of follow through with ideas and suggestions, and after you've collaborated and come up with solutions, and things like this, following through on them, uh, is sometimes not happening. When they don't follow through, it becomes quite discouraging (Participant 3).

The experiences of collaboration seemed quite varied across the group of participants; however, it was clear that the majority felt this was an element of practice that could be improved upon in the home. Also, the PSWs felt that their overall experience would be much more positive if they were able to be more involved in the collaborative process, particularly around resident care. The participants felt that they are

often not given the chance to be involved, provide input, or share their knowledge with other disciplines in the home. This theme will be explored in the next section.

Major Themes

The sections that follow present the themes that emerged in relation to the main research question that guided this study. The first theme presented centers on the PSWs' desire to play a more active role in collaboration and the final two focus on the factors that encouraged and discouraged collaboration in the home. Verbatim quotes taken from the interviews with participants are used to describe and support the findings. The data source of each quote is indicated as was done above.

Three themes emerged in response to the research question '*How do personal support workers (PSWs) describe their experience of collaboration in the long-term care home setting?*' The generated themes are:

1. *Valuing PSWs' Contributions* – The first theme presented centers around the desire that the PSWs have to be more involved in collaboration regarding resident care. It also highlights the intimate knowledge that PSWs possess and how they want their contributions to be better valued and recognized.
2. *Organizational Structure* – This theme describes how the established structure within the home, as well as education, scope of practice, task designation and resource allocation can positively and negatively impact collaboration.
3. *Individual Characteristics and Relationships* – This theme identifies how particular personality traits of the individuals involved in the collaborative process can both encourage and discourage collaboration. It also explores how strong and

weak relationships amongst the various individuals and disciplines in the home influence collaboration.

Theme One – Valuing PSWs Contributions. The first theme that emerged from the data regarding PSWs' experiences of collaboration was a theme that was woven throughout all of the participants' interviews and that is *Valuing PSWs' Contributions*. This theme explores the fact that the PSWs in this home feel that they have something significant to contribute to resident care and care planning and that they want those contributions to be both recognized and valued. They also discussed how this exclusion can prevent truly collaborative practice from occurring.

One element of this theme was that PSWs provide the most direct care to the residents within the home and have intimate knowledge of the residents as a result of that. Participant 3 stated: *"There's information that the PSWs have, uh, with knowledge and working on the floor, where the uh, nurses in charge, management etc... may not have because they are not on the front line with the residents, right."* This intimate knowledge could also help to achieve the overall goal in long-term care of providing the residents with personalized, resident-centered services. Participant 2 describes the detail and the intimacy of the knowledge that PSWs possess:

We know the residents' habits, we know their sleeping patterns, we know their eating habits, we know their bowel habits... we know what makes them happy, we know what makes them sad, we could write books on every one of them. And that could help so much with care. And, and I think also it could help a lot with cutting back on medications, like when they are agitated, we know you know that if you gave them a cup of tea and a couple cookies and let them sit up for an hour they would go to bed easier, than you know just popping an extra sleeping pill in them.

As a result of this that the PSWs think there is a need for more collaboration with registered staff and increased involvement when developing care plans for residents.

Without the information they provide, it would be much more difficult to make care decisions:

PSWs do bring all the information there, and without that information, they wouldn't be able to make those decisions. So as much, as much as we give them, that they are able to make a good, informed decision. So yes, absolutely, PSWs do and need to play a role in that (Participant 1).

The problem arises in that the PSWs in this study thought that they had been largely excluded from the collaborative process regarding resident care and are never asked to share their knowledge. Participant 8 touched on this by saying: *"There isn't always a chance to share what you know to solve a problem, or give better care [...] If they asked you, it would definitely help make it [collaboration] happen more often".*

Participant 7 further articulated this point:

Your front line staff never get asked anything, never, from patients' preferences to the way someone gets transferred, to um, the way you should set up a room, what works best. They, we never get asked that and we are the front line staff, and we are the ones that would know better than anyone else, especially when it comes to things like the activities of daily living, obviously meds, we have no idea, but everything else, your front line staff should be the ones that are asked more than the other staff.

Some of the PSWs also expressed that management is not always open to discussion or collaboration and this is demonstrated by their use of a top-down approach to communication as described below:

They come out in their suits and heels, you know, and they are just telling us, dictating to us what needs to be done. This is policy, this is policy, that is policy. And, and, it makes for unintimate care with the resident. You're really taking away from the residents. (Participant 5)

Similarly, Participant 8 articulated that the *"people who make the decisions don't seem to care what we have to say. So, eventually you think what you have to say isn't important."*

By under-valuing or not acknowledging their contributions, some PSWs stressed

that it directly impacts the resident's care, which should be the number one priority in long-term care homes. The PSWs in this study asserted that by not using all sources of knowledge available, you cannot be sure that the best resident care is being delivered. Participant 6 reflected on this: *"These residents are paying good money for the care they are getting, but are not necessarily getting the care they deserve."* This exclusion can also be emotionally challenging for the PSWs who have developed personal connections to the residents and their families, as described by two participants below:

It's tough because I love my residents, I want to give them good care all the time, but I can't. Um, like, no, no, definitely not always. It should be about the residents, it should always be about them, but it isn't (Participant 4).

They just are not listening and they make it quite clear that they don't want us discussing issues with the families, but um, you know, I keep putting my parents in those residents' spots, and I know what I would want for my parents. Anyways, it's a bugger (Participant 2).

Further to the emotional challenges presented to the PSWs as result of being undervalued, it has prompted one participant to explore PSW positions outside of long-term care, positions where they feel their contributions may be more valuable. Participant 4 acknowledged:

I think in the community, PSWs are more valued, [...] In the community, as a PSW, you are everything; in the home, you are nothing. It's very thankless. People don't listen to you, they don't want to listen to you, you are just a PSW. It's hard, it's very very hard to be a PSW in long-term care (Participant 4).

Finally, in regards to valuing PSWs contributions, one participant strongly advocated for PSWs being regarded as more than just unregulated healthcare workers who are often seen as the bottom of the hierarchy in the home. She expressed the need for PSWs to better recognized in this setting, as they play an extremely important role in the day-to-day care of the residents and overall functioning of a home. She explains:

I really wish people would stop saying, 'you are just a PSW' or 'I am just a PSW', we are not just anything. Uh, places like this home could not run without us, residents could not be properly cared for without us, and I think we have a lot to offer, and its important to remember that. It's our job, yes, but it's about the care of the residents, I think, uh, uh, that comes first, and I think we play a big part in that (Participant 3).

If the role PSWs played in long-term care was better recognized, then perhaps their contributions would be more highly regarded among their peers.

Theme Two: Organizational Structure. The second theme that emerged from the participant interviews as having a direct influence on their experience of collaboration in the home was the organizational structure. The structure that exists within the home is quite hierarchal and defines how the different disciplines interact, but also how tasks are designated and how care is delivered. The results presented in this theme take a largely negative view, with the participants conveying how the organizational structure often impedes collaboration.

Management. All participants referenced management in one regard or another in their interviews as a major factor that makes collaboration challenging in this organization. As detailed at the beginning of this chapter, this home has undergone some significant changes in management over the past several years as a result of new ownership. Two participants spoke at length about how this has changed the overall environment of the home, with one stating:

We were privately owned, and we've been recently taken over by the hospital, new management, everything, new everything. And I find that worse. It feels government run. I find it, I find it cold and political, it's no longer about teamwork, it's about, just get it done (Participant 5).

In addition, the PSWs in this study generally felt that the new management does not always understand what it takes to be a PSW in long-term care - "*Management don't*

have the empathy it takes I guess. It takes a certain kind of person to do a PSW jobs”
(Participant 5).

Another factor in regards to management that is affecting collaboration is the issue of staff favoritism. Half of the study sample made reference to this in some capacity. Some of the PSWs expressed that they do not try to collaborate with management, while others do, because they are not held in any special regard. Participant 6 asserted that:

They only go by a certain number of staff, if you aren't in their group or whatever, they don't care what you have to say [...] If I brought something to their attention, they may not listen to me, but if it was a certain PSW that they hold on a pedestal, if they said the exact same thing, it would be the greatest gift in the world.

Participant 3 seems to affirm that if you hold a certain position as a PSW, you are more highly regarded. She stated: *“I think it puts me in a better position, like more recognized by management, more than others”*. Overall, this differing standard of treatment towards and felt by PSWs on the part of management make it difficult for the PSWs to have a clear sense of when and who to collaborate with.

There is also, according to the PSWs, an overall lack of willingness on the part of management to involve and collaborate with the PSWs. One participant expressed: *“It's shunned on, it's definitely not received well when we make suggestions [to management] (Participant 5).”* This exclusion of PSWs contributions was explored in Theme #1.

Education. As previously mentioned and evidenced in this study, education can vary greatly amongst PSWs based on when they took the training over the course of their careers. This has resulted in PSWs having varying levels of knowledge. Three participants discussed this in their interviews, suggesting that this can make working with

other PSWs increasingly difficult because of their difference in opinions on practice. One participant articulated this by stating:

There are a lot of staff that have been doing this job right out of high school, so there is minimal education. And some of them in fact did this job in high school, so they don't have the same education as someone who would be coming out of school now. [...] There is a big difference in the knowledge and understanding of what you get when you go to school and what are just grandfathered into (Participant 1).

Another PSW supported this by discussing how she has experienced the changes in PSW training throughout her career, *"I've been a PSW for a long time but had a refresher course about 8 years ago, so I see it, the difference in the way things are done"* (Participant 4). This varied approach to practice based on education leads to some PSWs wanting to work with individuals with similar education and not wanting to work with someone whom they perceive has better or different education.

Scope of practice. Varying levels of education have not only influenced how PSWs are able to work with one another, but also how PSWs are able to work with members of disciplines who hold a higher education in the healthcare field. The PSWs in this study view the different scopes of practice as creating a hierarchy within the home, which can directly influence collaboration. Two participants made reference to this – *"It just seems that the different ranks can make it easier or harder to work together (Participant 5)"* and *"Those who help are, how do I say that, like those who don't feel they are above that" (Participant 7).*

Some of the PSWs further expressed that the registered staff are not always willing to help a PSW with daily tasks, such as toileting because it is not part of their scope of practice in the home. Participant 5 describes this experience:

You might get an occasional RN that will help and push someone down to the dining room or something like that, but it's not part of their job detail [...] They're sitting at the desk, they're doing nurse work, that's what they are doing, it just seems unfair because of their job title.

This lack of involvement by some registered staff in the direct care of the residents from the perspective of some PSWs has led to increased tension among staff. Participant 1 reflected on this:

I think that's where the conflict comes from in this, the nursing staff, umm, they make the decision. But when you are actually doing all the work and bring them the information, but they get to make the decision, there's a hardship there.

The varying roles and expectations are not only problematic in regards to PSW-registered staff collaboration, but it also prevents this process from occurring between PSWs. One PSW expressed that if a resident is not a particular PSW's assigned resident, they do not feel the need to help if required. Participant 4 stated:

They don't give a darn about them because they aren't their residents. Yes, they've been told they aren't responsible for your resident. So, if they fall out of bed and they don't have their call bell on, they're laying on the floor, that comes on me and she [the other PSW] knows that.

Overall, the sentiment is that resident care is not a shared responsibility between the team; it is that of one person, which adds support to the next sub-theme.

Time constraints. When considering the level of direct care provided by the PSWs to residents in the home, another factor that negatively affects their experience of collaboration was highlighted. All of the participants in the study discussed how time constraints and task designation impede their ability to effectively work with others. One participant stated that,

We don't have a lot of time to talk to one another about residents, to other PSWs or RPNs or nurses. We have to go from one [resident] to the other to the other, no time in between, there's not time for teamwork (Participant 4).

The PSWs' large caseloads in this home also seem to affect their ability to collaborate with others with the goal of providing more resident-centered care and services.

Definitely caseload. That's a huge factor and I think it always will be. [...] There's just no time to be that specific or that individualized. You may know what a resident wants but it's not always easy to deliver (Participant 7).

In addition to no time to collaborate and provide individualized services, PSWs highlighted the notion that even if there was more time, there is a lack of material support.

Lack of resources. The final sub-theme that emerged from the data in relation to organizational structure was the lack of resources available to support effective collaboration. While this was a factor that was only briefly discussed by a couple of the participants, it is important to note in the results. One participant discussed how lack of financial resources makes it difficult for management to follow through on collaborative efforts. She stated:

I find the lack of willingness to support, uh, the needs that you have. Financially, they are not willing to, in the nursing home, to go and spend some extra finances on the things that you need in there [...] (Participant 3).

The same participant went on to discuss how the lack of a communal and private space within the home to meet makes it difficult to share knowledge and discuss residents.

If you are asking for a place to gather in a small home like ours, there is no place to gather, everybody is fighting for rooms. So that's uh, something that we would have to work around (Participant 3).

And finally, the lack of replacement staff for PSWs to attend meetings and sit on committees, mentioned by two participants, means that they are not able to attend and contribute. Participant 2 discussed her experience:

I've been asked to go on a lot of committees right, and to resident-centered care committees but uh, I'm not replaced off the floor when the meetings are housed, so I'm just a name on an agenda and I don't know why they do that [...] I can't attend any of these meetings so my word never means anything because I am not there to give it (Participant 2).

While the participants have discussed a number of factors at the organizational level as having an influence on collaboration, there are also factors to consider at the individual level when describing the PSWs current experiences of collaboration.

Theme Three – Individual Characteristics and Relationships. According to the PSWs in this study, a major element of collaboration is working together, and in order for that process to be successful, the individuals involved must embody certain characteristics. The unique qualities of each individual have been shown to either facilitate collaboration or hinder it, leading to our final theme.

Characteristics that encourage collaboration. When reviewing the data, several qualities that encourage collaboration amongst co-workers were identified. Having an open-mind and a willingness to consider others' ideas was important. One participant explained, *"It depends on who you are working with on any given day. Some people are certainly more willing to listen to what you have to say and try something new"* (Participant 8) and another expressed that it's about *"understanding everybody's views and insight. And uh, [it's] about being open-minded to change. Accepting it."* (Participant 1). In addition to being open to change, two participants spoke to the fact that you have to be assertive and willing to fight for that change when you think something needs to be addressed by your colleagues. The participant provided evidence for this when she stated:

Sometimes we have to get a little bit loud or a little bit unprofessional with our peers to get them to listen. Um, and when I say unprofessional, its trying to put all your, um, professionalism aside and become a little more assertive when you think that things are not being, uh, attention isn't being paid to, um, issues with the resident that I think might be overlooked. We get after the nurses to take a second look, or bring it to the doctor.

Accountability was another quality that a participant discussed in regards to supporting collaboration. She felt that if everyone was more accountable for their actions, the situation would improve, *"I think the PSWs need to be more accountable for what they are doing. And I think when they are more accountable for they are doing, there would be better communication and collaboration throughout the whole home"* (Participant 1).

Characteristics that discourage collaboration. Being resistant to change, or closed-minded, was one of the most referenced characteristics in terms of preventing collaboration. Five study participants spoke to the challenges that this can present in the workplace. It was often discussed in reference to an individual having worked as a PSW for an extended period of time, over 30 years for example, and wanting to continue to do things the way they were taught and/or trained. This finding ties into the earlier discussion about individuals wanting to work with others who have a similar educational background. Moreover, some individuals are not willing to work together because they have never had to. A participant spoke about both of these points:

Like I think it sometimes comes down to people wanting to do things differently. Like some of the girls that have been there a long time, want to do things differently than some of the new girls, so they don't do things together [...] And like I said, some of the girls don't want to work together because they don't like the way the other girls do things, or don't want to change how they do things (Participant 4).

A lack of confidence was also identified by one participant as a quality that prevents her from effectively collaborating with others. Participant 8 expanded on this: *"I sometimes*

am not like, hmm, how do I say this, like not confident in what I have to say.” This lack of confidence leads to individuals not communicating when necessary.

Communication skills. The importance of an individual's communication skills cannot be understated. Throughout the course of data analysis, it became quite apparent that all participants believe these skills are vital in the collaborative process. They discuss the significance of two-way communication, *“Listening and talking to one another, no matter who it is. We need to share what we know and what we think with everyone, and we need to listen to what they want to say”* (Participant 4). The participants also discussed the importance of registered staff trying to engage in effective communication with PSWs in order to solicit resident information. Participant 2 highlights that, *“We have to seek them out [...] But we are a library of information for them, so they would just come and ask us once and a while.”* It was also noted that it is important to know with whom you need to communicate, and thus, with whom to collaborate, when certain situations with the residents arise.

You are going to communicate with the proper department that has the information um, because if I need to know if this resident is confused and doesn't know where they are, I need to know where to get that information as to where they used to live so that I could find some common things that I can talk to that individual to help eliminate confusion right. So I would go to the activities department because they find out about the resident. I could go to the nurses and ask for the care plan. (Participant 3)

Quality of Relationships. The quality of one's workplace relationships can play an important role in the collaborative process, and Participant 8 expressed that it is important that these relationships *“encourage you to work together, like support you trying to be more involved in the resident's care”*. And these types of relationships for the PSWs in this home do not just spontaneously happen but are developed over time.

Several participants referenced working with another for several years prior to arriving at a place where they would prefer to work together rather than apart. Participant 4 described this occurrence:

Um, I would say, uh (...) who the person is. Like, some of the girls, I've worked with for years, so its easy to work them. You know they're routine, they want to help you out, they'll listen to the information you have on a resident. [...] With some girls there, we do teamwork right up the hall, and its wonderful, because we can get them up just as fast working together on them, as working singularly (Participant 4).

And this idea of working well with people you've worked with for years is likely as a result of the time it takes to develop a mutual trust amongst individuals involved in collaboration. You need to know that you can rely on one another for help: *"You have to trust the girls that you are on shift with that they will do the job (Participant 4)."*

Conversely, when well-developed relationships and a sense of shared responsibility do not exist between the different individuals in the home, collaboration is less likely to occur. Several PSWs in this study indicated that there is a lack support and a clear disconnect amongst the various disciplines. One participant expressed that working together becomes increasingly difficult when the potential collaborator would rather criticize than assist:

There is a lot of backstabbing [...] Ya, you know, someone running to management and saying this or that. If you make one mistake or do one thing that isn't exactly policy, you have girls running to management. Everyone is looking out for themselves. Uh, [...] just makes it hard to want to work with other people, ever (Participant 6).

Another participant described how she doesn't want to work with other people in the home because she doesn't trust their intentions and does not want them to succeed at her expense:

Its also difficult to like, figure out who to talk to about stuff, who to trust. There are definitely people in there that as soon as you screw up, like as soon as you screw up, go to the bosses to tell them because it looks good on them, but bad on you. So why would I want to work with them, tell them what I know about the resident to make their job easier (Participant 5).

When the general sentiment becomes that of lack of trust and that each person is looking out for himself or herself, collaboration becomes extremely challenging.

However, when a positive, strong relationship can be developed amongst co-workers in the workplace, it fosters better teamwork. When team members who know, trust, and respect each other, there may be more of increased willingness to collaborate for the betterment of care delivery: *“There’s a couple girls and I that when we get together on our unit, we work great together (Participant 6).”* And when individuals are able to work together, based on strong relationships and teamwork skills, improved outcomes are more likely to occur and it is the hope that this will encourage future collaboration amongst those individuals. Participant 2 spoke about this: *“Ultimately seeing success. So if we’re, I, I work with some girls that have worked there for a long time and we work together really well, so umm, success is the motivation that keeps us going on to the next project” (Participant 2).*

Summary

The PSWs in this study define collaboration as *a group of people working together to achieve the shared goal of delivering the best possible care to residents.*

While a definition was developed based on the PSWs responses to the question ‘how do you define the term collaboration?’, it is important to note that there was evidence of a lack of a clear understanding of what the concept means. In addition, the act of collaborating was most commonly described as occurring on an intradisciplinary basis,

meaning with other PSWs or unregulated staff in the home. While it did not occur as often, the PSWs also described collaborating with registered staff, including registered nurses and registered practical nurses, and residents and their families; however, there was only a brief mention of collaborating with management, indicating that perhaps this occurs even less frequently. Collaboration was viewed as a process that was largely problem or solution driven. Participants would engage in a collaborative process with others when they were trying to identify the source of a problem or when they needed to develop a solution for an already identified problem. And when describing the experience overall, the PSWs presented a number of different viewpoints. While some indicated that collaboration is happening in the home with everyone playing a role, the majority of the study participants had either mixed or negative opinions. They described an experience that occurs to some degree, but an experience that is often challenging and one that the PSWs are largely excluded from for various reasons.

Three themes emerged from the data regarding PSWs' experiences of collaboration, with the first theme highlighting the PSWs desire to be more involved and more valued in the collaborative practice, specifically regarding resident care, while the other two themes demonstrate the organizational and individual factors that encourage and discourage the PSWs involvement. Table 1 provides a summary for the three themes discussed in this chapter.

Table 1

Summary of Key Themes

Theme 1 – Valuing PSWs' Contributions	Theme 2 – Organizational Structure	Theme 3 – Individual Characteristics and Relationships
<p>PSWs have intimate knowledge regarding the residents that they want to share</p> <p>They are given minimal opportunity to contribute or be involved in care planning</p> <p>Not involving PSWs negatively effects resident care</p> <p>PSWs want their contributions to be valued and when they feel they are, they will contribute more</p>	<p>Inconsistent management approaches and changes in ownership do not support collaboration</p> <p>Varying education and scope of practice are also barriers to collaboration</p> <p>Heavy workloads and time constraints make it difficult to collaborate</p> <p>Lack of resources to support collaboration</p>	<p>Being open-minded, assertive, and accountable encourage collaboration</p> <p>A lack of confidence, closed-mindset, and being resistant to change discourage collaboration</p> <p>Communication skills are vital in this process</p> <p>Relationships based on support and trust are needed to successfully collaborate</p>

In Chapter Five, novel findings from this study will be discussed and connections are made between the results presented here and the existing literature. Concluding comments and thoughts are also presented.

Chapter 5 – Discussion & Conclusion

This chapter examines the findings from the participant interviews in light of relevant literature. These findings will also be explored in relation to the Structuration Model of Interprofessional Collaboration presented in Chapter 2. Strengths and limitations of the study are then described. The implications/recommendations of the findings in regards to education, clinical practice and future research are also presented.

Personal support workers (PSWs) are the frontline workers who have the most frequent contact with and are the most intimately involved in the care of nursing home residents (Caspar & O'Rourke, 2008; Sharkey, 2008; Snellgrove et al., 2015), and the level of care that they provide has recently been linked to resident quality of life (Lerner, Johantgen, Trinkoff, Storr & Han, 2014; Shaw, 2014). However, evidence has shown that they are often excluded from care planning and decision-making (Caspar & O'Rourke, 2008; Cranley et al., 2012), which potentially limits the ability of staff to deliver quality, resident-centered care (Kontos et al., 2010). While the literature on PSWs is increasing, particularly regarding their role in care delivery, job satisfaction, burnout and turnover, there is little research regarding their role in care planning and collaborative practice. More specifically, there are no studies to date that look at PSWs' experiences of collaboration. This is particularly problematic, as the current model of care in these settings requires collaboration amongst various disciplines to successfully meet residents' needs (Grabowski et al., 2014). Therefore, this study intended to develop a better understanding of how PSWs experience collaboration and what factors encourage or discourage this process.

Discussion of Study Themes

Theme One – Valuing PSWs Contribution. PSWs are the primary caregivers for an increasingly vulnerable population of individuals living in long-term care homes. By providing the most direct care to residents and by being the largest segment of the healthcare workforce within these settings, PSWs should be more highly regarded and valued. Many studies to date have highlighted the fact that PSWs have intimate knowledge of care needs due to their proximity and frequency of contact with residents (Barry et al., 2005; Banerjee et al., 2015; Kontos et al., 2010; Potter & Grant, 2004), and the participants in this study felt no differently. They believed that their role in the home should warrant their inclusion in care planning; yet, the PSWs felt that they were given minimal opportunity to be included or involved. These findings are consistent with those of Caspar and O'Rourke (2008), Colon-Emeric et al. (2006), Cranley et al. (2012), and Kontos et al. (2010) who found that PSWs were largely excluded from resident care planning and were not consulted during the decision-making process. A possible reason for this exclusion is the traditional and hierarchal medical model that endures in long-term care where those with the least resident contact have the most control regarding care decisions (Rahman & Schnelle, 2008). PSWs suggested that the issue of top-down management persists and that there is a continued disconnect between those making the care decisions and those carrying out the care plan. The work by Banerjee et al. (2015) supports this, as they found that PSWs still feel that “current policy [does] not reflect the reality of care work” (p. 33) and that this is a “fundamental barrier to quality” (p.34).

While this theme was largely consistent with previous literature, it did, however, capture a unique element of the PSWs' experience of collaboration and that is that PSWs

want a voice, and they want that voice to be both heard and recognized. This strong desire to be a valued and respected part of the collaborative process, particularly in relation to resident care decisions and planning, was perceived as a major influence on subsequent involvement in collaboration and the PSWs' overall experience. Studies have shown the value of PSWs inclusion in this process. Caspar and O'Rourke (2008) found that increased frontline staff decision making was related to the adoption of more individualized, patient/resident centered care, and when given the opportunity, PSWs have shown their ability to lead a collaborative effort for quality improvement initiatives (Norton et al., 2014). However, the participants indicated that even though there are increased opportunities to contribute, the process is still difficult.

The findings of this study suggest that PSWs occasionally have the opportunity to collaborate with others; however, they expressed that their opinion is not always considered, and there is often a lack of follow through on the information and knowledge that they provided to registered staff or management. When the PSWs felt as though their contributions were not rewarded and/or recognized, it resulted in a lack of confidence in their knowledge. A similar sentiment was captured in Janes et al. (2008) study on PSWs' knowledge utilization in dementia care settings where PSWs "struggled to feel valued for their contributions to residents' care and used many derogatory labels to describe how they think their work is viewed by others, including 'the lowest of the low of nursing' and 'grunt labour'" (p. 19). This lack of recognition not only led to a decreased confidence in their knowledge, but the PSWs also indicated that it directly affected their motivation to continue to try to be involved. This direct link between recognition and motivation (Janes at al., 2008) was also noted in the study above. This lack of motivation

coupled with a heavy workload compelled the PSWs in this study to disregard the importance of collaboration in the interest of just “getting things done”. Therefore, PSWs may choose to not engage in the collaborative process as it is going above what is expected of them. And if they do put forth that additional effort and see no direct results or are not recognized by registered staff/management in a positive way, they remove themselves from the process altogether.

An interesting caveat of this finding is that there are some emotional repercussions for the PSWs when their contributions are not well received or utilized. The findings suggest that the PSWs often viewed themselves as advocates for the residents and when their opinions were not valued or integrated, they had no voice and in turn, felt the residents had no voice. This proved particularly challenging for PSWs as they often viewed their parents in place of the residents, knowing what they would want for their family members, and even expressed feelings of love and affection for the residents in their care. Overall, if the PSWs were not given the opportunity to collaborate or did not feel that their contributions were integrated when allowed the chance, they felt less inclined to collaborate, directly influencing their overall experience.

Theme Two – Organizational Structure. The PSWs reported that several organizational structures impeded their ability to successfully collaborate with others in the home. Those barriers largely centered on resource issues, organizational leadership and role structure. Collaboration requires time and an opportunity to connect with peers; however, PSWs' current workload in the home makes this difficult. Staffing and workload issues have been consistently identified in the literature as major barriers to shared decision-making and collaboration regardless of discipline or setting (Leutz,

Bishop & Dodson, 2010; Moore & Prentice, 2015; Yeatts et al., 2015). A decreased PSW to resident ratio would allow for more time with a resident to learn their preferences and care needs, while also allowing for more time throughout their shift to debrief with or assist others. This would also potentially allow PSWs to participate in care planning meetings because there would be more PSWs on the unit to cover during their absence. Other resource issues include a lack of available spaces for PSWs to discuss residents with other team members and limited financial support for compensation/reward for good work or for innovation resulting from collaborative efforts. This was an issue that PSWs held the management of the home responsible for addressing.

Organizational leadership was something that was woven throughout the study themes, particularly in regards to barriers. Recent ownership and leadership changes had been difficult for the PSWs. The strong relationships and rapport that they had developed with the previous owners, who were also in management positions, ceased to exist as new staff has been hired, and the opportunity to build those strong relationships with the new management has not occurred. This made it increasingly difficult for PSWs to feel as though they can approach management with their knowledge or concerns. PSWs indicated that this is further compounded by the fact that it is not always clear as to what is expected of them and what they can expect of others within the home.

Building on this, role expectations were also considered an obstacle to collaboration. The PSWs cited various occasions where they required assistance in feeding the residents, responding to their bells, or transferring them, but regulated staff did not help because it was not perceived as part of their job. However, the PSWs felt that if all staff embraced a more 'just-do-it or pitch-in' attitude, the effects would be felt

throughout the home and it would be mutually beneficial to all those involved (Leutz et al. 2010). This would help to further foster the interpersonal, reciprocal relationships required in collaboration.

Another barrier in relation to role was the lack of clarity around what certain positions did. This has been described in healthcare research as role ambiguity (Moore & Prentice, 2015) or unclear role boundaries (McNaughton, Chriem & Bourgeault, 2013). The problem arose specifically when a select group of PSWs were given certain roles and special designations within the home that set them apart. Personal support workers felt that these individuals were given more opportunities to collaborate and that their contributions were held in higher regard. Role expectations, therefore, varied amongst the group, which led to some feeling that there is an issue of staff favouritism. This led to tension and decreased communication, as some feared that those individuals would inform management if errors occurred or policy was not followed. They became less interested in collaborating with these individuals. However, some PSWs may not recognize that these positions often necessitate more frequent contact with management and regulated staff. There needs to be more consensus regarding role expectations and responsibilities for all positions (D'Amour et al., 2008), in order to decrease the feelings of staff favouritism and increase contact between management and PSWs, thus increasing collaboration.

Theme Three – Individual Characteristics & Relationships. Possessing certain individual characteristics was perceived by the PSWs as a facilitator of collaboration. These characteristics included such things as being open-minded, assertive and accountable. However, individual characteristics were also viewed as potential barriers,

and included being resistant to change, closed-minded, and lacking confidence to voice one's opinion. The findings in this study support the literature on the impact that individual attributes have on the quality and frequency of interprofessional interactions (D'Amour et al., 2008; McNaughton et al., 2013; Moore & Prentice, 2015).

As evidenced by the findings and discussion thus far, it is not surprising that the importance of interpersonal relationships is evident throughout the study's findings. The majority of the enabling factors and barriers to collaboration presented have some influence on the development of relationships including time to connect, space to convene and skills to communicate. And these relationships appear to be the foundation of strong, efficient collaborative processes in this home. This is supported by literature that suggests the "quality of relationships in LTC facilities may have a direct and meaningful influence on care aides' [PSWs] ability to provide individualized care" (Caspar & O'Rourke, 2008, p. S263). These relationships also appear to develop based on what Farrell (2001) refers to as a collaborative circle. Similar to the findings of Moore and Prentice (2015), collaboration amongst the PSWs was "influenced by the existence of a prior and/or current relationship" (p. 6), and when the PSWs "invested in a positive way in the relationship; collaboration was successful. Whereas if interaction was negative or neglected, the relationship was poor and collaboration was unsuccessful" (p. 6). This cyclical effect was also evident in regards to feeling valued by regulated staff. When PSWs felt as though their opinions and knowledge were valued, they began to trust and respect regulated staff. This respect and trust within the relationship subsequently led to their opinions being further valued, which is a key factor in the PSWs overall experience as discussed in Theme #1.

Study Findings and the Structuration Model of Interprofessional Collaboration

Collaboration is a way of working, organizing, and operating in a method that utilizes all available resources to deliver health care in an efficient and effective manner to meet the needs of patients/clients/residents (Way et al., 2000). The Structuration Model of Interprofessional Collaboration was developed to explore the complex mechanisms involved in this group process (D'Amour et al., 1999; D'Amour et al., 2005; D'Amour et al., 2008). While this model was originally created based on findings from a primary healthcare setting involving professional disciplines, its applicability to other settings and healthcare providers has been demonstrated. In light of the findings from this study, the model's four dimensions, *shared goals and vision*, *internalization*, *formalization* and *governance*, are examined for its relevance to PSWs in long-term care.

Shared Goals and Vision refers to common goals, allegiances, definitions, and expectations of collaboration. D'Amour et al. (2008) stress the importance of having shared goals, as well as the ability to reach them. It is considered an essential starting point to any collaborative venture. The findings of this study suggest that PSWs share a common goal and that is delivering the best possible care to the residents. The issue, according to them, is the ability to achieve that goal due to their exclusion from care decisions and lack of information exchange with regulated staff and management. As evidenced by the common goal that PSWs hold, their loyalty is to the resident first. However, the lack of communication has, at times, led to a loss of focus on resident-centered care as the PSWs become discouraged and no longer try to engage in a collaborative process in which they share intimate resident knowledge.

Internalization focuses on the establishment of trusting relationships. This mutual trust promotes the exchange of information between individuals and helps to develop an awareness of their interdependence (D'Amour et al., 2008). In our study, internalization was demonstrated through the discussion of relationships as the basis of collaborative efforts. Personal support workers expressed that they were more likely to collaborate with others when there was a pre-existing personal and professional relationship. These relationships were built over time, as several of the PSWs had been working in the home for many years, several on the same shifts, and that allowed them to anticipate others reactions and feel confident in each other's ability. The PSWs also expressed that when collaboration was successful, they were more likely to collaborate with other PSWs and regulated staff in the future. This is perhaps because the results of collaboration are used to evaluate and further build trust between individuals (D'Amour et al., 2008).

Formalization is concerned with the larger organizational setting and the rules that are meant to regulate action through structure. This dimension highlights the need for professionals to know what is expected of them and what they can expect from others (D'Amour et al., 2008). This proved particularly problematic for the PSWs involved in this study. As discussed previously, expectations varied depending on which individual PSW to whom they were applied, thus leading to an overall lack of clarity regarding their role and responsibilities. There also seemed to be some confusion on the part of PSWs regarding the role of other members of the healthcare team and the nature and boundaries of their scope of practice. The PSWs demonstrated a need for management to more clearly outline expectations and apply them consistently to avoid uncertainty and confusion. There is also a need for meetings, which discuss the roles and responsibilities

of others in the home. Role clarification, which is one of the six core competencies of interprofessional collaboration, highlights the importance of understanding one another's role. It helps to establish team goals, but can also aid others in identifying individuals' unique skills and knowledge (Canadian Interprofessional Health Collaborative [CIHC], 2010). In addition, there were minimal sources of information, such as the Resident Assessment Instrument – Minimum Data Set, that PSWs felt they had full access to that supported consistent communication and feedback. Only one PSW mentioned she had access to the computer to facilitate care, while the majority indicated they were not part of meetings with other team or family members and did not see care plans.

Governance is the final dimension of the model to be examined and it relates to the regulation of collaboration between different individuals. As discussed, the PSWs expressed that there was confusion regarding the PSWs role, particularly in collaboration, as reactions to their contributions to care plans or suggestions regarding practice varied among the regulated staff and management. This points to the lack of a central authority in providing a clear direction for this group of healthcare providers in relation to collaborative processes (D'Amour et al., 2008). It was also evident that PSWs often did not take the proper initiative to develop and support collaboration. This is largely because PSWs felt leadership regarding care and care decisions was not shared, which translated into their lack of motivation to be involved, exclusion from decision making and their opinions not being heard. It has been shown that when leadership is not shared in collaborative efforts, there is often a lack of support regarding decisions made by other parties (CIHC, 2010); therefore, developing a leadership structure that is mandated but also initiated is key.

Overall, this model provided a theoretical framework on which to evaluate findings for this study. Similar to that of professional healthcare workers, PSWs discussed several barriers and facilitators that influence their experience of collaboration that align with the four dimensions of the model. Theme 1 and 3 presented in the results chapter relate to the relational dimensions of shared goals and vision and internationalization, while Theme 2 mirrors that of the organizational dimensions of formalization and governance. Personal support workers, in spite of sharing a common goal of optimal resident care, described a lack of opportunity and support to collaborate, as well as underdeveloped relationships that a collaborative practice requires. Overall, according to the typology presented by D'Amour et al. (2008), the PSWs' current experience of collaboration appears to be somewhere between potential/latent collaboration and developing collaboration, where collaborative achievement is minimal.

Strengths & Limitations

This study aimed to develop a description of PSWs' experiences of collaboration in long-term care homes and the factors that influence it. A noted strength of this study was the qualitative descriptive design, which allowed for an in-depth analysis of the phenomenon of interest from the PSWs themselves. The semi-structured nature of the interview was also considered a strength as it encouraged a more open discussion of items that the PSWs deemed important regarding their experience and that may not have been captured by the original interview questions.

The participants in this study were recruited on a voluntary basis, which often involves a certain degree of self-selection bias, in that the decision to participate may reflect similar traits and/or characteristics of the participants. The sample, therefore, may

not have been representative of the entire population. Moreover, as this study was confined to one rural, for profit nursing home in the Champlain LHIN, the findings are only pertinent to this study; however, data saturation was achieved in that no new relevant information was emerging at the end of data collection. This would suggest that the captured experience, including barriers and facilitators, was complete. This was further validated through the use of member checks with participants, where no questions or concerns regarding the findings presented were flagged; suggesting the PSWs felt their experience was well described. Therefore, the perspectives on this experience that were identified may be relevant and transferable to PSWs' experiences in other homes. In addition, the sensitive nature of the subject matter seemed to limit the amount and specificity of details shared by some participants. Certain individuals felt uncomfortable expanding on negative comments about their experiences, colleagues, and/or the long-term care home, which limited discussion. For several participants, this unwillingness to discuss further was compounded by their general uneasiness about research and relative distrust of the researcher (resulting from the recruitment presentation being made at a formal staff meeting). Although the concept of anonymity was reviewed with the participants and guaranteed, the fear of repercussion or reprisal appeared to influence what and how much they shared.

Implications & Recommendations

A number of implications and recommendations are discussed under the topics of clinical practice, education and future research. These recommendations are based on the study findings and are supported by the literature. A summary of these recommendations is provided in Table 2.

Table 2

Recommendations

Education <ol style="list-style-type: none"> 1. Educational institutions must teach PSWs what collaboration is and what successful collaboration can look like 2. Nursing staff and management need to learn how to foster effective interdependence and reciprocal relationships
Practice <ol style="list-style-type: none"> 1. Development of a collaborative practice model tailored for long-term care 2. PSWs need an opportunity to collaborate 3. Provide PSWs with an effective method to collaborate 4. Management and regulated staff need to provide PSWs with recognition when a contribution is made 5. Management should provide PSWs and other staff with social conditions that promote interaction
Future Research <ol style="list-style-type: none"> 1. Conduct a study on nursing staff and management experience of collaborating with PSWs in the home 2. Explore the feasibility of including PSWs in a SBAR-based approach to communication

Education. As evidenced by the participants in this study, PSWs' lack a clear and concise understanding of the term collaboration and its related processes. Therefore, the first recommendation centers on educating PSWs on this type of care delivery. While training of PSWs varies as a result of the training being offered in a variety of settings as detailed in above, there have been significant strides in reforming their education. While not a standard curriculum, the Ontario Ministry of Training, Colleges and Universities (MTCU), in July of 2014, released a common education standard for PSWs that details

14 vocational learning outcomes, along with essential employability skills and general education requirements (Kelly & Bourgeault, 2015; MCTU, 2014). What is encouraging is that two of the 14 vocational learning outcomes discuss PSWs role in collaboration, and the essential skills outlined support that role (MCTU, 2014). This would suggest that new PSWs are receiving at least some education around the subject of collaboration. However, in the absence of a standard curriculum, it is essential that their training, regardless of setting, incorporate a base of theory of collaboration, as well as clinical placement that involve working in an interdisciplinary, collaborative team when possible. This collaboration-based training would offer PSWs the opportunity to develop the skills required for successful collaboration, as well as an understanding of the organizational behaviours that can affect this complex process.

What remains to be seen is how these standards and renewed focus on collaboration for PSWs will affect those PSWs who have completed training and are currently working in the home. Continuing education is not always perceived as available for PSWs. In fact, one study showed that 39.6% of PSWs indicated there was little to no discussion of further training or education opportunities (Caspar & O'Rourke, 2008). Therefore, it is my recommendation that a continuing education training session on collaboration, with a particular focus on the development of the six core competencies outlined in the National Interprofessional Competency Framework (CIHC, 2010), is developed and offered to the all PSWs regardless of start date, and supported by management through replacement staff or compensation for attendance.

In addition to increasing PSWs education regarding collaboration, there is also a need for management to be trained on how to develop more reciprocal relationships

between frontline staff and nursing home management. Participants in this study detailed a divide between PSWs and regulated staff/management. That divide impedes their sense of team and teamwork, which are concepts directly related to their understanding of collaboration, and results in a lack of interdependence among staff members. According to Toles and Anderson (2014), managers play a key role in fostering interdependence and encouraging reciprocal staff conversations regarding resident care. Therefore, it was their recommendation, which the findings of this study further support, that management engages in continued training focused on relationship-oriented management practices (Toles & Anderson, 2014). Literature also supports this inclusion in staff nurse education (Toles & Anderson, 2014). Similar to that of the PSWs and management, an education session should be developed for staff nurses on interdisciplinary collaboration with a strong focus on the roles that different team members play and communication techniques to foster efficient communication. In addition to further education and training, clinical practices need to be implemented to support PSWs role in collaboration.

Practice. As evidenced by study results, the PSWs view collaboration as a single event or occurrence and do not understand that collaboration is a healthcare philosophy that should be incorporated into their daily practice. One way in which this could be achieved is through a collaborative practice model. While there are several models in existence, they largely focus on collaborative practice in acute care, in-patient settings (Campbell, Fryers, Devitt, & Vestal, 2009; Murphy, Alder, MacKenzie & Rigby, 2010), or they focus on outlining curricula for collaborative practice training and competencies (CIHC, 2010; WHO, 2010), and do not necessarily take into account the contextual differences between acute and residential care. Therefore, the first practice

recommendation is the development of a collaborative practice model specifically tailored for the long-term care setting. Similar to the models discussed above and reflecting the participants' (PSWs') current understanding of the term collaboration, this model should be resident-centered and involve all healthcare providers working together and communicating frequently to address the complex health problems of those living in long-term care. This model should also reflect the current staff composition of long-term care, which is primarily PSWs (OLTCA, 2014), and use language that is relevant to this body of healthcare worker and be introduced/implemented by demonstrating how this model/process fits into their practice. This language and process should be utilized by all staff, particularly management, to ensure the philosophy becomes more embedded in PSWs' practice.

Studies have shown that PSWs and other direct care providers are more likely to participate in shared decision-making, an element of collaboration, when managers and regulated staff share information, listen to PSWs ideas, and subsequently discuss ideas with them (Yeatts, Shen, Yeatts, Solakoglu, & Seckin, 2015). Several clinical practice recommendations are outlined and could encourage collaboration if implemented, the first being that PSWs need an opportunity to collaborate, the ideal way being through formal team conferences. This inclusion in team sharing allows PSWs to have access to primary sources of knowledge that can inform their care and also gives PSWs a chance to share their knowledge with others (Janes et al., 2008; Snellgrove et al., 2015). These opportunities need to be further supported by management as adequate staff, time and an available place to have open discussion are required for PSWs to engage in this process (Yeatts et al., 2015). In addition, PSWs need a method to effectively collaborate with

others when these opportunities are provided. Therefore, the development of a communication tool with the specific aim of ensuring PSWs are involved in the discussion regarding resident care is important. This tool would provide PSWs with an outline of what knowledge to share and how to do so effectively and efficiently to support their continued involvement. In the study by Howe (2014) in which a PSW-led communication and teamwork intervention was explored, a 5-minute, three question debriefing session at the end of the day shift was implemented to encourage discussion among the PSWs, floor nurses and other interdisciplinary team members. At the end of the study, PSWs indicated that these debriefing sessions had “given them more confidence to raise issues or concerns [...] and felt that the nurses listened to them more attentively” (p. 135). These opportunities gives the PSW confidence to exchange knowledge with others, and a standardized tool may assist the regulated staff and management with trusting and respecting what the PSWs are telling them as the questions allow information to be reported regularly and consistently.

Caspar and O'Rourke (2008) found that 54.6% of PSWs feel that they receive few if any rewards or recognition for a job well done, and the PSWs in this study indicated that that is an important influence on their experience of collaboration. Therefore, in addition to being given the opportunity to participate in collaboration, PSWs need to be recognized for their contributions. This recognition can be demonstrated in a variety of ways. The integration of their knowledge into a resident's care plan is one way this can be accomplished, as well as praise for their efforts and hard work. Personal support workers in this study noted they fear reprisal if involve themselves in caregiving decisions when not directly asked; however, recognition of their efforts to do what is best

for residents regardless of outcome has been shown to mitigate PSWs becoming discouraged and can be seen a source of motivation (Janes et al., 2008). As highlighted by the participants, rewards have also been found to encourage PSWs involvement and sense of responsibility in care (Yeatts et al., 2015). These could be in the form of performance-based financial rewards; however, one study found that intrinsic rewards, such as supervisor support and input into job tasks, were better predictors for job satisfaction and engagement (Morgan, Dill & Kalleberg, 2013). The findings of this study, supported by previous research, continue to highlight the importance of PSWs feeling valued by their peers and superiors.

Finally, to address the issue of the frustration that arises from PSWs feeling that their contributions were not integrated after collaboration had occurred, management and regulated staff need to take the time to try to provide an explanation as to why it has not been incorporated to show respect for the PSWs opinion. This suggested practice is supported by the findings presented in Yeatts et al. (2015). In doing this, management not only educates the PSWs on clinical practice and care decisions, but it also helps to encourage future involvement.

The last practice related recommendation is more indirectly related to collaboration than those outlined above. Relationships have been shown to be an important factor in fostering collaboration. Therefore, it is important that PSWs, along with other staff, are provided with the opportunity to interact socially and get to know one another not only a professional level, but also on a personal level. This could be achieved through lunch and learns which are less formal and less structured than regular training. A focus on organizational issues or initiatives in these sessions could foster

awareness of activities between the departments, as well as provide the participants with a better understanding of what other individuals in the home do. In addition, the participants often commented that they are more likely to collaborate with and assist someone with whom they have a developed relationship and to whom they feel accountable. The development of these organized labor and management relationships has been shown to lead to more clinically focused labor negotiations, greater person-centeredness, and improved staff satisfaction (Leutz et al., 2010), thus, its importance in collaboration cannot be understated.

Future Research. Several new research questions arise from this study and this thesis illuminates the need for a better understanding of collaboration involving PSWs. This study focused on the PSWs' experiences of trying to collaborate with others in the home and what obstacles and facilitating factors influence it. What was not explored in this study is the experience of regulated staff and/or management when trying to collaborate with the PSWs. Therefore, in future research, it would be interesting to explore through a qualitative descriptive study similar to the one outlined in this study how other disciplines describe their experience of collaboration when PSWs are involved. By capturing various perspectives, it allows for a more complete and multifaceted description of the experience, but it also provides an opportunity to compare and contrast those to determine if there are any similarities and/or differences that could further inform educational reform and clinical practice changes.

Another potential avenue for future research could focus on PSWs involvement in structured communication protocols within the home. Specifically, the SBAR - situation, background, assessment and recommendation - approach (Institute for Healthcare

Improvement, 2011), which provides a structured method of communication, is becoming increasingly and commonly used in healthcare settings and has shown some utility and positive outcomes in long-term care (Field et al., 2011; Renz, Boltz, Wagner, Capezuti & Lawrence, 2013; Whitson et al., 2008). However, to date, PSWs have not been involved in the research regarding the utility and feasibility of this tool in long-term care. As PSWs provide the majority of direct care in these settings, they are in a key position to assess changes on a 24-hour basis, and their effective communication with other members of the healthcare team could allow for the early identification of symptoms that could influence clinical decisions (Renz et al., 2013). Similar to the study outlined in Renz et al. (2013), a repeated measure design could be employed to assess the influence of SBAR protocol and training on communication amongst team members using a pre-post questionnaire. While this study focused on registered nurses and licensed practical nurses and their communication with the medical staff (as perceived by the nurses and the physicians), there would be some value in including the PSWs, particularly in regards to the *situation* and *assessment* elements of the protocol. As indicated above, PSWs may be the first to note new symptoms with a resident, and therefore, could inform the *situation* (symptoms, onset, duration), and then subsequently could inform the *assessment* by providing a description of appearance, which is consistent with their scope of practice (Renz et al., 2013). Training sessions and the pre-implementation questionnaire would need to be geared towards all staff providing direct care, and continued support would need to be available throughout the study. After the intervention period is finished, all participants would complete a follow-up questionnaire. In regards to outcome measures relating to PSWs (the focus would not be on physicians as PSWs rarely have direct communication

with them), there would be a particular focus on PSWs satisfaction of involvement in care decisions, as well as nurse perception of PSW/nurse communication (Renz et al., 2013).

In Renz et al. (2013), the nurses felt that the SBAR-based approach to communication helped to organize their thinking, and they felt more confident, valued and respected as a result. PSWs indicated the latter as a major barrier to collaboration; therefore, it would be interesting to see if similar outcomes were found between PSW-nurse communications when using a communication protocol such as the one outlined above.

Further suggestions for future research include a longitudinal study in which the same PSWs are interviewed in 5 years to see if their involvement in or experience of collaboration has improved as a result of the continued culture change movement towards person- and resident-centered care. It could also include a comparative study of student nurses in a PSW role vs. trained PSWs to see if there are differences in their experience of collaboration.

Conclusion

As long-term care homes are becoming increasingly complex care environments serving a more vulnerable population than ever before (OACCAC, 2011; OLTCA, 2014), the need for successful collaboration cannot be overlooked. In order to be successful, all healthcare providers within the home, whether regulated or not, must share a common goal and must play a role in achieving that goal. However, the current literature reveals that PSWs, the largest segment of the long-term care workforce who have the most frequent and direct contact with residents, are often excluded from this process (Caspar & O'Rourke, 2008; Kontos et al., 2010). In order to better address this issue, it first needs to be understood. Therefore, this qualitative descriptive study looked to develop a

description of the current experience of collaboration of PSWs in long-term care.

Specifically, the study explored their current understanding of collaboration, whom they collaborate with, and what factors encouraged and/or discouraged their involvement in this process. Since few studies have focused on PSWs, particularly in regards to collaboration, the findings of this study are valuable.

The analysis revealed that the PSWs shared a common goal, which was to deliver the best possible care to residents. This delivery of quality care was accomplished through teamwork, a concept that was central to the PSWs understanding of the term collaboration. But when discussing successful teamwork, it was often in relation to working with other PSWs or unregulated care providers on daily care routines. There was an expressed desire amongst the PSWs though, to be more involved in the teams that actively collaborate on resident care decisions, particularly regulated staff and management, because they felt their knowledge of residents was fundamental in the ability to deliver individualized care. However, their experiences with these multidisciplinary teams were characterized by feelings of being undervalued and unacknowledged. This lack of opportunity to be involved or lack of recognition when efforts are made to be involved, coupled with underdeveloped relationships, resource constraints, and the hierarchy that persists in the home, make for a collaborative experience that the participants described as difficult, frustrating, and largely not occurring. Future research should look at how to better involve PSWs in collaboration and incorporate their intimate resident knowledge into care plans. As research regarding collaboration in long-term care homes is limited, the findings of this study add important knowledge to the development of a more multi-faceted view of this type of practice.

Specifically, the findings highlight the potential role that PSWs can play in collaboration, their desire to be more involved, and how best to support that involvement.

References

- American Medical Directors Association Ad Hoc Work Group on the Role of the Attending Physician and Advanced Practice Nurse. (2011). Collaborative and supervisory relationships between attending physicians and advanced practice nurses in long-term care facilities. *Geriatrics Nursing*, 32, 7-17.
- Anderson, R.A., Ammarell, N., Bailey, D., Colón-Emeric, D., Corazzini, K., Lekan Rutledge, ... Utley-Smith, Q. (2005). The Power of Relationships for High Quality Long-term Care. *Journal of Nursing Care Quarterly*, 20(2), 103-106.
- Almost, J., & Laschinger, H. (2002). Workplace empowerment, collaborative work relationships, and job strain in nurse practitioners. *Journal of the American Academy of Nurse Practitioners*, 14(9), 408–420.
- Banerjee, A., Armstrong, P., Daly, T., Armstrong, H., & Bradley, S., (2015). “Careworkers don’t have a voice:” Epistemological violence in residential care for older people. *Journal of Aging Studies*, 33, 28-36.
- Barry, T.T., Brannon, D., & Mor, V. (2005). Nurse aide empowerment strategies and staff stability: Effects on nursing home resident outcomes. *The Gerontologist*, 45, 309-317.
- Beaulieu, M.D., Denis, J.L., D’Amour, D., Gaudreau, J., Haggerty, J., Hudon, É., et al. (2006). L’implantation des Groupes de médecine de famille: le défi de la réorganisation de la pratique et de la collaboration interprofessionnelle. Montreal: Université de Montreal. Retrieved from http://www.ferasi.umontreal.ca/fra/07_info/Rapport_GMF_mars_2006_F.pdf

- Berta, W., Laporte, A., Zarnett, D., Valdmanis, V., & Anderson, G. (2006). A pan-Canadian perspective on institutional long-term care. *Health Policy*, 79(2-3), 175-194.
- Blair, C.E., & Glaister, J.A. (2005). Making the most of nursing homes' number one resources. *Healthcare Management Review*, 30(2), 110-115.
- Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative Research in Psychology*, 3(2), 77-101.
- Campbell, B., Fryers, M., Devitt, R., & Vestal, K. (2009). Towards a collaborative model of care. *Healthcare Management Forum*, 22(3), 27-31.
- Canadian Health Association. (2009). New directions for facility-based long-term care. Ottawa, Canada: Canadian Health Association.
- Canadian Interprofessional Health Collaborative. (2010). A national interprofessional competency framework. Vancouver, BC. Retrieved from http://www.cihc.ca/files/CIHC_IPCompetencies_Feb1210.pdf
- Caspar, S. & O'Rourke, N. (2008). The influence of care provider access to structural empowerment on individualized care in long-term care facilities'. *The Journal of Gerontology. Series B, Psychological Sciences and Social Sciences*, 63(4), S255-S265.
- Colón-Emeric, C.S., Lekan-Rutledge, D., Utley-Smith, Q., Ammarell, N., Bailey, D., Piven, M.L., & Anderson, R.A. (2006). Connection, regulation, and care plan innovation: A case study of four nursing homes. *Healthcare Management Review*, 31(4), 337-346.

- Colón-Emeric, C.S., Lekan, D., Utley-Smith, Q., Ammarell, N., Bailey, D., Corazzini, K., & Anderson, R.A. (2007). Barriers to and facilitators of clinical practice guideline use in nursing homes. *Journal of American Geriatrics Society*, 55(9), 1404-1409.
- Corazzini, K., McConnell, E.S., Rapp, C.G., & Anderson, R.A. (2004). A conceptual framework for understanding the decision-making processes of nursing assistants in providing dementia care. *Alzheimer Care Quarterly*, 5(3), 197-206.
- Cranley, L., Norton, P., Cummings, G., Barnard, D., Batra-Garga, N., & Estabrooks, C. (2012). Identifying resident care areas for a quality improvement intervention in long-term care: A collaborative approach. *BMC Geriatrics*, 12(59).
- Creswell, J.W. (2013). *Qualitative inquiry and research design: Choosing among five Approaches* (3rd ed.). Thousand Oaks, CA: SAGE.
- Crozier, M., & Friedberg, E. (1977). *L'acteur et le système: les contraintes de l'action collective*. Paris, Editions du Seuil.
- D'Amour, D., Ferrada-Videla, M., San Martin Rodriguez, L., & Beaulieu, M. (2005). The conceptual basis for interprofessional collaboration: Core concepts and theoretical framework. *Journal of Interprofessional Care*, 19(S1), 116-131.
- D'Amour, D., Goulet, L., Labadie, J.F., San Martin-Rodriguez, L., & Pineault, R. (2008). A model and typology of collaboration between professionals in healthcare organizations. *BMC Health Services Research*, 8, 188.
- D'Amour, D., Goulet, L., Pineault, R., Labadie, J.F., & Remondin, M. (2004). Comparative study of interorganizational collaboration and its impact: The case of perinatal services. Montreal: University of Montreal. Retrieved from: http://www.ferasi.umontreal.ca/fra/07_info/Rapport%20ANG.pdf

- D'Amour, D., Sicotte, C., & Levy, R. (1999). Un modèle de structuration de l'action collective dans les services de santé de première ligne au Québec. *Sciences Sociales et Santé*, 17(3), 67-94.
- Davies, S., & Nolan, M. (2006). 'Making it better': Self-perceived roles of family caregivers of older people living in care homes: A qualitative study. *International Journal of Nursing Studies*, 43(3), 281-291.
- Deutschman, M. (2001). Redefining quality & excellence in the nursing home culture. *Journal of Gerontological Nursing*, 27(8), 28-36.
- Farrell, M. (2001). Collaborative circles: Friendship, dynamics, and creative work. Chicago, IL: University of Chicago Press.
- Fewster-Thuente, L., & Velsor-Friedrich, B. (2008). Interdisciplinary collaboration for healthcare professionals. *Nursing Administration Quarterly*, 32(1), 40-48.
- Field, T., Tjia, J., Mazor, K., Donovan, J., Kanaan, A., Harold, L., ... Gurwitz, J. (2011). Randomized trial of a warfarin communication protocol for nursing homes: an SBAR-based approach. *American Journal of Medicine*, 124(2), 179.
- Flesner, M.K. (2009). Person-centered care and organizational culture in long-term care. *Journal of Nursing Care Quality*, 24(4), 273-276.
- Forbes-Thompson, S., Leiker, T., & Bleich, M.R. (2007). High-performing and low performing nursing homes: A view from complexity science. *Healthcare Management Review*, 32(4), 341-351.
- Fraser, K., O'Rourke, H., Baylon, M.A., Boström, A.M., & Sales, A. (2013). Unregulated provider perceptions of audit and feedback reports in long-term care: Cross

sectional survey findings from a quality improvement intervention. *BMC Geriatrics*, 13, 15.

Grabowski, D.C., O'Malley, J., Afendulis, C.D., Caudry, D.J., Elliot, A., & Zimmerman, S. (2014). Culture change and nursing home quality of care. *The Gerontologist*, 54(S1), S35-S45

HealthForceOntario. (2007). Interprofessional care: A blueprint for action in Ontario. Retrieved from http://www.healthforceontario.ca/UserFiles/file/PolymakersResearchers/ipc_blueprint-july-2007-en.pdf

Holloway, I. & Wheeler, S. (2010). *Qualitative Research in Nursing and Healthcare* (3rd ed.). United Kingdom: John Wiley & Sons Ltd.

Howe, E. (2014). Empowering certified nurse's aides to improve quality of work life through a team communication program. *Geriatrics Nursing*, 35(2), 132-136.

Institute for Healthcare Improvement. (2011). SBAR technique for communication: A situational briefing model. Retrieved from <http://www.ihl.org/resources/pages/tools/sbartechinqueforcommunicationasituationalbriefingmodel.aspx>

Janes, N., Sidani, S., Cott, C., & Rappolt, S. (2008). Figuring it out in the moment: A theory of unregulated care providers' knowledge utilization in dementia care settings. *Worldviews of Evidence-based Nursing*, 5(1), 13-24.

Kemper, P., Heier, B., Barry, T., Brannon, D., Angeleli, J., Vasey, J., & Anderson-Knott, M. (2008). What do direct care workers say would improve their jobs? Differences across settings. *The Gerontologist*, 48(S1), 17-25.

- Kelly, C. & Bourgeault, I. (2015). A common education standard for PSWs in Ontario. *Health Reform Observer*, 3(1). doi: dx.doi.org/10.13162/hro-ors.v3.i1.169
- Kontos, P., Miller, K. & Mitchell, G. (2010). Neglecting the importance of the decision making and care regimes of personal support workers: A critique of standardization of care planning through the RAI/MDS. *The Gerontologist*, 50(3), 352-362.
- Kontos, P., Miller, K., Mitchell, G., & Cott, C.A. (2011). Dementia care at the intersection of regulation and reflexivity: A critical realist perspective. *Journal of Gerontology: Series B: Psychological Sciences and Social Sciences*, 66(1), p. 119-128.
- Koren, M. (2010). Person-centered care for nursing home residents: The culture-change movement. *Health Affairs*, 29(2), 312-317.
- Krefting, L. (1991). Rigor in Qualitative Research: The Assessment of Trustworthiness. *The American Journal of Occupational Therapy*, 45(3), 214-222.
- Laverty, S. (2003). Hermeneutic phenomenology and phenomenology: A comparison of historical and methodological considerations. *International Journal of Qualitative Methods*, 2(3).
- Lerner, N.B. Johantgen, M., Trinkoff, A., Storr, C., & Han, K. (2014). Are nursing home survey deficiencies higher in facilities with greater staff turnover? *Journal of the American Medical Directors Association*, 15(2), 102-107.
- Leutz, W., Bishop, C. & Dodson, L. (2010). Role for a labor-management partnership in nursing home person-centered care. *The Gerontologist*, 50(3), 340-351.
- Lincoln, Y.S. & Guba, E. G. (1985). *Naturalistic Inquiry*. Beverly Hills, CA: SAGE.

Long Term Care Innovation Expert Panel [LTCIEP]. (2012, March). Why not now? A bold, five-year strategy for innovating Ontario's system of care for older adults.

Retrieved from <http://www.ifafiv.org/wpcontent/uploads/2012/12/>

LTCIEPFullREport_web_jun6.pdf

MacNaughton, K., Chreim, S., & Bourgeault, I. (2013). Role construction and boundaries in interprofessional primary healthcare teams: A qualitative study. *BMC Health Services Research, 13*: 486.

McCormack, B., & McCance, T. (2010). Person-centered nursing: Theory, models and methods. *Journal of Advanced Nursing, 565*, 1-8.

McGilton, K., Heath, H., Chu, C., Boström, A.M., Mueller, C., Boscart, V., ... Bowers, B. (2012). Moving the agenda forward: a person-centered framework in long-term care. *International Journal of Older People Nursing, 7*, 303-309.

McGilton, K., Irwin-Robinson, H., Boscart, V., & Spanjevic, L. (2006). Communication enhancement: nurse and patient satisfaction outcomes in complex continuing care facility. *Journal of Advanced Nursing, 54*(1), 35-44.

Ministry of Health and Long-Term Care. (2015). *New Long-Term Care Home Quality Inspection Program*. Retrieved from:

http://www.health.gov.on.ca/en/public/programs/ltc/31_pr_inspections.aspx

Ministry of Training, Colleges, and Universities. (2004). *Personal Support Worker*

Program Standard (MTCU funding code 41469). Retrieved from

<http://www.tcu.gov.on.ca/pepg/audiences/colleges/progstan/health/supportworker.pdf>

- Ministry of Training, Colleges, and Universities. (2014). *Personal Support Worker Program Standard*. Retrieved from <http://www.tcu.gov.on.ca/pepg/audiences/colleges/progstan/health/41469.pdf>
- Moore, J., & Prentice, D., (2015). Oncology nurses' experience of collaboration: A case study. *European Journal of Oncology Nursing*, 19(5), 509-515.
- Morgan, J., Dill, J., & Kalleberg, A. (2013). The quality of healthcare jobs: Can intrinsic rewards compensate for low extrinsic rewards? *Work, employment and society*, 27(5), 802-822.
- Morley, J. (2014). Certified nursing assistants: A key to resident quality of life. *Journal of the American Medical Directors Association*, 15(9), 610-612.
- Murphy, G.T., Alder, R., MacKenzie, A., & Rigby, J. (2010). Model of Care Initiative in Nova Scotia (MOCINS): Final Evaluation Report. Retrieved from novascotia.ca/dhw/mocins/docs/MOCINS-evaluation-report.pdf
- Murray, M.A., Higuchi, K., Edwards, N., Greenough, M., & Hoogeveen, K. (2011). Practice change in long-term care facilities in Ontario: Views of Managers and Staff. *Geriatric Nursing*, 32(4), 418-428.
- Neergaard, M. A., Olesen, F., Andersen, R.S., & Sondergaard, J. (2009). Qualitative description – the poor cousin of health research? *BMC Medical Research Methodology*, 9(52).
- Norton, P., Murray, M., Doupe, M., Cummings, G., Poss, J., Squires, J., ... Estabrooks, C. (2014). Facility versus unit level reporting of quality indicators in nursing homes when performance monitoring is the goal. *BMJ Open*, 4, e004488.
- Novick, G. (2008). Is there a bias against telephone interviews in qualitative research?

Research in Nursing Health, 31(4), 391-398.

O'Brien, J., Martin, D., Heyworth, J., & Meyer, N. (2009). A phenomenological perspective on advanced practice nurse-physician collaboration within an interdisciplinary healthcare team. *Journal of the American Academy of Nurse Practices*, 21, 444-453.

Ontario Association of Community Care Access Centres. (2011). Factors influencing wait Times for Long-Term Care Homes [PowerPoint slides]. Presentation to OLTCA and OANHSS, Toronto.

Ontario Community Support Association [OCSA]. (2009). The history and development of the Personal Support Worker and Personal Attendant Programs in Ontario.

Retrieved from

http://www.psno.ca/uploads/1/0/1/9/10197937/the_history_and_development_of_the_personal_support_worker_and_personal_attendant_programs_in_ontario.pdf

Ontario Long-Term Care Act. (2007). Retrieved from <http://www.e>

[laws.gov.on.ca/html/source/regs/english/2010/elaws_src_regs_r10079_e.htm](http://www.laws.gov.on.ca/html/source/regs/english/2010/elaws_src_regs_r10079_e.htm)

Ontario Long-Term Care Association. (2013). Ontario Long-Term Care Association

Annual Report. Retrieved from

http://www.oltca.com/system/files/Reports/Annual/OLTCA_Annual_Report_2013_final.pdf

Ontario Long-Term Care Association. (2014). This is long-term care, 2014. Retrieved

from http://www.oltca.com/oltca/Documents/Reports/This_is_LongTerm_Care_2014_Final.pdf

- Patton, M.Q. (2002). *Qualitative research & evaluation methods (3rd ed.)*. Thousand Oaks, CA: SAGE.
- Petri, L. (2010). Concept analysis of interdisciplinary collaboration. *Nursing Forum*, 45(2), 73-82. doi: 10.1111/j.1744-6198.2010.00167.x
- Pillow, W. (2003). Confession, catharsis, or cure? Rethinking the uses of reflexivity as methodological power in qualitative research. *Qualitative Studies in Education*, 16(2), 175-196.
- Potter, P., & Grant, E. (2004). Understanding RN and unlicensed assistive personnel working relationship in designing care delivery strategies. *Journal of Nursing Administration*, 34(1), 19-25.
- Rader, J., & Semradek, J. (2003). Organizational culture and bathing practice: Ending the battle in one facility. *Journal of Social Work in Long Term Care*, 2, 269-283.
- Rahman, A., & Schnelle, J. (2008). The nursing home culture-change movement: Recent, past, present and future directions for research. *The Gerontologist*, 48(2), 142-148.
- Reeves, S., Zwarenstein, M., Goldman, J., Barr, H., Freeth, D., Hammick, M., & Koppel, I. (2008). Interprofessional education: Effects on professional practice and health care outcomes. *Cochrane Database of Systematic Reviews*, 23(1).
- Renz, S., Boltz, M., Wagner, L., Capezuti, E., & Lawrence, T. (2013). Examining the feasibility and utility of an SBAR protocol in long-term care. *Geriatric Nursing*, 34(4), 295-301.

Roseman, C.A., Hanson, L.C., Ennet, S.T., Schenk, A.P., & Weiner, B.J. (2012).

Implementing person-centered care in nursing homes. *Healthcare Management Review, 37*(3), 257-267.

Sandelowski, M. (1995). Sample size in qualitative research. *Research in Nursing and Health, 18*(2), 179-183.

Sandelowski, M. (2000). Whatever happened to qualitative description? *Research in Nursing and Health, 23*, 334-340.

Sandelowski, M. (2010). What's in a name? Qualitative description revisited. *Research in Nursing and Health, 33*, 77-84.

Scott-Cawiezell, J., Jones, K., Moore, L., & Vojir, C. (2005). Nursing home culture: A critical component in sustained improvement. *Journal of Nursing Care Quality, 20*(4), 341-348.

Scott-Cawiezell, J., Schenkman, M., Moore, L., Vojir, C., Connolly, R., Pratt, M. & Palmer, L. (2004). Exploring nursing home staff's perceptions of communication and leadership to facilitate quality improvement. *Journal of Nursing Care Quality, 19*(3), 242-252.

Siegel, E., Anderson, R.A., Calkin, J., Charlene, H., Corazzini, K., Dellefield, M., & Goodman, C. (2012). Supporting and promoting personhood in long term care settings: contextual factors. *International Journal of Older People Nursing, 7*, 295-302.

Sharkey, S. (2008). People caring for people: Impacting the quality of life and care of residents of long-term care homes. A report of the independent review of staffing care standards for long-term care homes in Ontario. Retrieved from

http://www.health.gov.on.ca/en/common/ministry/publications/reports/staff_care_standards/staff_care_standards.pdf

Shaw, P.A. (2014). Nursing home assistants and quality nursing home care. *Journal of the American Medical Directors Association*, 15, 609.

Shier, V., Khodyakov, D., Cohen, I.W., Zimmerman, S. & Saliba, D. (2014). What does evidence really say about culture change in nursing homes? *The Gerontologist*, 54(S1), S6-S16.

Sjorgen, K., Lindkvist, M., Sandman, P, Zingmark, K., & Edvardsson, D. (2013). Person centeredness and its association with resident well being in dementia care units. *Journal of Advanced Nursing*, 69(10), 2196-2206. doi: 10.1111/jan.12085

Snellgrove, S., Beck, C., Green, A., & McSweeney, J. (2015). Putting residents first: Strategies developed by CNAs to prevent and manage residents-to-resident violence in nursing homes. *The Gerontologist*, 55(S1), S99-107

Statistics Canada. (2011). Living arrangements of seniors. Retrieved from http://www12.statcan.ca/census-recensement/2011/as-sa/98-312-x/98-312-x2011003_4-eng.cfm

Statistics Canada. (2012). Population projections for Canada, provinces and territories. Retrieved from <http://www.statcan.gc.ca/pub/91-520-x/91-520-x2010001-eng.pdf>

Statistics Canada. (2014). Population projections: Canada, the provinces and territories, 2013 to 2063. Retrieved from <http://www.statcan.gc.ca/daily-quotidien/140917/dq140917a-eng.htm>

Statistics Canada. (2015). Canada's population estimates: Age and sex, July 1, 2015.

Retrieved from <http://www.statcan.gc.ca/daily-quotidien/150929/dq150929b-eng.htm>

Stone, R. (2001). Research on frontline workers in long-term care. *Generations*, 25(1), 49-57.

Toles, M., & Anderson, R. (2011). State of science: Relationship-oriented management practices in nursing homes. *Nursing Outlook*, 59(4), 221-227.

Wagner, L., Damianakis, T., Mafrici, N., & Robinson-Holt, K. (2010). Falls communication patterns among nursing staff working in long-term care settings. *Clinical Nursing Research*, 19(3), 311-326.

Way, D., Jones, L., & Busing, N. (2000). Implementation strategies: "Collaboration in primary care – Family doctors & nurse practitioners delivering shared care": Discussion paper written for the Ontario College of Family Physicians. Retrieved from <http://www.eicp.ca/en/toolkit/hhr/ocfp-paper-handout.pdf>

Whitson, H., Hastings, S., Lekan, D., Sloane, R., White, H. & McConnell, E. (2008). A quality improvement program to enhance after-hours telephone communication between nurses and physicians in a long-term care facility. *Journal of the American Geriatrics Society*, 56, 1080-1086.

Winn, P., Cook, J., & Bonnel, W. (2004). Improving communication among attending physicians, long-term care facilities, residents, and residents' families. *Journal of the American Medical Directors Association*, 5, 114-122.

World Health Organization [WHO]. (2010). Framework for action on interprofessional education & collaborative practice. Geneva: WHO Press.

- Yeatts, D. & Cready, C. (2007). Consequences of empowered CAN teams in nursing home settings: A longitudinal assessment. *The Gerontologist*, 47(3), 323-339.
- Yeatts, D., Shen, Y., Yeatts, P., Solakoglu, O., & Seckin, G. (2015). Shared decision making in nursing homes: Factors associated with the empowerment of direct care workers. *Journal of Aging and Health*, 1-23. doi: 10.1177/0898264315600689
- Zimmerman, S., Shier, V., & Saliba, D. (2014). Transforming nursing home culture: Evidence for practice and policy. *The Gerontologist*, 54(S1), S1-5.
- Zwarenstein, M., Reeves, S., Barr, H., Hammick, M., Koppel, I., & Atkins J. (2004). Interprofessional education: effects on professional practice and healthcare outcomes. *Cochrane Database Systematic Review*, 3, 1-13.

Appendix A



Personal Support Workers' Experience of Collaboration in a Long-Term Care Facility in Rural Ontario

Long-term Care Home Information Letter

Dear Administrator/Director of Care:

I am contacting you in regards to a research study entitled *Personal Support Workers' Experience of Collaboration in a Long-Term Care Facility in Rural Ontario* conducted by myself, Katie Hoogeveen, under the supervision of Dr. Dawn Prentice, RN PhD of Brock University. This study is part of the thesis component of my Master's Degree in Applied Health Sciences, Community Health, and I am interested in discussing the topic of interest with personal support workers from your home.

What is the purpose of this study?

I am interested in how personal support workers experience collaboration in your long-term care home and what factors encourage or discourage this collaboration.

What does this study involve?

Should your organization agree to allow me to recruit personal support workers working within your home, I would ask that I be allowed to attend an upcoming staff meeting in order to speak to the personal support workers directly to discuss their potential involvement in the study.

The desired number of personal support workers for this study is 8-10. Their participation would involve an audio-taped interview, 30-45 minutes in length, conducted either face-to-face or via telephone. The participant will determine the mode of the interview. These personal support workers will be asked about their experience of collaboration in the long-term care home. All interviews will be conducted outside of the personal support worker's scheduled work hours and outside of the workplace setting, at a time and location (if applicable) that is acceptable to the potential participant. The participant will be given a summary of key themes that emerged from the data to confirm and comment on if desired via feedback form in March of 2015. They will be given a \$10 Tim Horton's gift card as a thank-you for their participation in the study.

What are the benefits of participating in this study?

While there are no direct benefits to participant, participation in this study by personal support workers from your home will expand knowledge about how they currently experience collaboration and what factors encourage and/or discourage their role in collaborative practice. A copy of the final report will be provided to you at the end of the study – July 31st, 2015. A copy of the final report will also be made available to the study participants upon request at that time.

What about confidentiality?

All transcripts and results will be reported using pseudonyms that are matched to the identifying information of the participant on a separate sheet of paper maintained by the student investigator in a locked filing cabinet at their personal residence. It will not be possible to identify your home or any colleagues names as these will also be given pseudonyms that will be recorded on a separate sheet as described above. Direct quotes provided by the participant may be used in summary reports. However, we will always remove any identifying information from the quotes as well.

What about resident privacy and confidentiality?

This research does not involve interviewing residents or family members of the Home. I do not require access to personal health information. Published reports will not cite any identifying resident, personnel, or home information.

Has this research received ethics approval?

This research received ethics approval from the Brock University Research Ethics Board (file #14-052 PRENTICE).

Should you be interested in allowing us to contact personal support workers from your home, I will require a letter of permission from you as soon as possible granting us permission to access your premises and employees. You can fax this letter back to Katie Hooegeveen at 613-448-2519 or you can scan and e-mail it to kh13uc@brocku.ca.

I also ask that you provide me with date/times of upcoming staff meetings for which I can attend to recruit participants.

If you have any questions or concerns about this research, please contact the student investigator for this project, Katie Hooegeveen at 613-858-3159 or by e-mail at kh13uc@brocku.ca. You may also contact my supervisor, Dr. Dawn Prentice at 905-688-5550 ext. 5161 or by e-mail at dprentice@brocku.ca

Ethical concerns may be directed to the Research Ethics Officer, Brock University at 905-688-5550 ext. 5182 or by e-mail at reb@brocku.ca

Student Investigator: Katie Hooegeveen, BA, MA(c), Brock University

Student Supervisor: Dawn Prentice, RN, PhD, Brock University

Appendix B**Personal Support Workers' Experience of Collaboration in a Long-Term Care Facility in Rural Ontario****Participant Information Letter and Informed Consent Form****Dear Participant:**

You are invited to participate in a study entitled *Personal Support Workers Experience of Collaboration in a Long-Term Care Facility in Rural Ontario* conducted by myself, Katie Hoogeveen, under the supervision of Dr. Dawn Prentice of Brock University. This study is part of the thesis component of my Master's Degree in Applied Health Sciences, Community Health.

What is the purpose of this study?

I am interested in how personal support workers experience collaboration in long-term care homes and what factors encourage and discourage this collaboration.

What does this study involve?

I would like to conduct an interview with 8-10 personal support workers. You will be asked to participate in an audiotaped interview lasting 30-45 minutes that is conducted either face-to-face or via telephone, whichever is your preferred option. You will be asked about your experience of collaboration in the long-term care home. All conversations will be outside of regularly scheduled work hours and outside of the workplace setting, at a time and location that is convenient for you.

You will be given a summary of key themes that emerged from the data to confirm and comment on via a feedback form after data collection and analysis is complete in March of 2015. You will receive this summary and feedback form in either hardcopy via mail or electronic copy via e-mail. You will be able to indicate your preference during the interview. You will be asked to review this summary and respond to the questions provided on the form, as well as provide any additional comments or concerns. You will be asked to return the completed form via mail or e-mail within two weeks. If the form is not received by this time, I will assume that you do not have any concerns and the themes regarding the experiences of collaboration have been captured accurately in the summary. This summary will be sent to you by March 2015. A copy of the final report will also be made available to you if requested. You will be able to request this final report by emailing or calling Katie Hoogeveen using the contact information provided below.

You will be given a \$10 Tim Horton's gift card at the end of the study as a thank-you for your participation. Should you wish to withdraw from the study prior to its completion, you will not receive this card.

What are the benefits of participating in this study?

Your participation in this study will increase knowledge about how personal support workers currently experience collaboration and what factors encourage and/or discourage their role in collaborative practice. There are no direct benefits for you.

Are there any risks from participating?

Risks to participating in this study are minimal.

What if I change my mind about participating in this study?

Participation is voluntary and you may refuse to answer any question(s) and/or withdraw from participation in the study at any time, without fear of reprisal. If you choose to withdraw, all data gathered from you up until that time will be destroyed. If you wish to withdraw, you can indicate this verbally during the interview or by contacting Katie Hooegeveen by telephone or e-mail with the contact information below.

What about confidentiality?

Your name will be recorded on a sheet matching your name with a pseudonym. Only the pseudonym will be marked on your transcript. The list matching your name with a pseudonym will be kept separately by the student investigator in a locked filing cabinet and will be destroyed at the end of the study. Your transcribed interview will have your name removed and only the pseudonym will identify you; therefore, participation will remain confidential. The study data will be stored for seven years following the completion of the study, after which time paper transcripts and records of responses will be destroyed.

All results will be reported using the de-identified data. It will not be possible to identify your home or any co-workers names you may say during the interview, as these will also be given pseudonyms as described above. Direct quotes may be used in summary reports; however, any identifying information will be removed.

Has this research received ethics approval?

This research received ethics approval from the Brock University Research Ethics Board (file #14-052 PRENTICE).

If you have any questions or concerns about this research, please contact the student investigator for this project, Katie Hooegeveen at 613-858-3159 or by e-mail at kh13uc@brocku.ca. You may also contact the student's supervisor, Dr. Dawn Prentice at 905-688-5550 ext. 5161 or by e-mail at dprentice@brocku.ca

Ethical concerns may be directed to the Research Ethics Officer, Brock University at 905-688-5550 ext. 5182 or by e-mail at reb@brocku.ca

If you are interested in participating in this research, please contact Katie Hooegeveen using the contact information provided above to discuss method of interview and date, time, and location (if applicable).

You are also asked to complete the Consent for Study form provided below. If a face-to-face interview has been arranged, this form can be completed and handed directly to Katie Hooegeveen at the time of the interview. If a telephone interview has been arranged, a participant can give verbal consent over the phone or return the signed consent form via fax (613-448-2519) prior to the call.

Student Investigator: Katie Hooegeveen, BA, MA(c), Brock University

Student Supervisor: Dawn Prentice, RN, PhD, Brock University



**Personal Support Workers' Experience of Collaboration in a Long-Term
Care Facility in Rural Ontario**

Consent for Study – Participant

I have read the letter of information, and I agree to participate in the study. All of my questions have been answered to my satisfaction.

Participant Name (*Please Print*): _____

Participant Signature: _____

Date: _____

There are two copies of this consent form in this document.

If a face-to-face interview has been arranged, this form can be signed and returned at the time of the interview. If a telephone interview has been arranged, you will be able to provide consent verbally over the phone.

The other copy is yours to keep.

Appendix C

Interview Guide

Investigator: “Prior to commencing, I would just like to remind you of the purpose of the research, which is to understand the experiences of collaboration of personal support workers in a long-term care facility. Our interview will be audiotaped and will take approximately 30-45 minutes; however, it may be shorter or longer depending on what is shared. There are several questions to guide our conversation today, but I encourage you to freely discuss whatever you feel is important regarding this experience. If at any time you have shared something that you do not wish to be recorded, please let me know. Also, if at any moment you wish to no longer continue, please let me know and we will we finish. Do you have questions before we begin?”

Telephone: “Have you read and understood the letter of information and consent form? Have all of your questions about the study been answered to your satisfaction? If so, do you agree to participate in the study?”

Face-to-face: “Have you read and understood the letter of information and consent form? Since you have now signed and returned the consent form, we are able to begin.”

Demographic Questions

Gender:

M_____ F_____

Age Range:

21 & under_____ 22-29_____ 30-39_____ 40-49_____ 50-59_____
60-64_____ 65 & over_____

What is your educational background?

Years (or months) experience as a personal support worker: _____

Years (or months) working in current long-term care home as a personal support worker: _____

Employment Status:

Casual _____ Part-time _____ Full-time _____

Guiding Questions

1. How would you define the term collaboration?
Prompts: Communication? Teamwork?
Further prompt if necessary: Collaboration is “multiple health workers from different professional backgrounds provide comprehensive services by working with patients, their families, carers and communities to deliver the highest quality of care across settings” (WHO, 2010, p.13).
2. How would you describe your experience of collaboration in the long-term care home setting?
3. With whom do you collaborate? Can you give me an example of a time when you collaborated in your work?
4. What factors encourage collaboration/collaborative practice?
5. What factors discourage collaboration/collaborative practice?
6. Do you have anything else that you would like to add?

“Thank you so much for taking the time to complete the interview for this study. I would just like to confirm with you, how you would like to receive the summary of key themes that emerged from the study to review after data collection and analysis is complete. I can send you the summary and feedback form via mail, with a return-stamped envelope for the completed feedback form, or via e-mail, where you can provide the feedback on the form electronically and return.”

“Could you please provide me with the proper address?”

Email address:

Mailing address:

Appendix D
Personal Support Workers' Experience of Collaboration in a
Long-Term Care Facility in Rural Ontario

Summary of Key Themes

Theme #1 – Organizational Structure

- ❖ PSWs' heavy workloads and lack of time make it difficult to collaborate within the home
- ❖ No designated space to share/exchange information and no replacement staff for PSWs to attend meetings make collaboration less likely to occur
- ❖ Varying education, job assignments and scope of practice are also barriers to successful collaboration between disciplines
- ❖ Changes in ownership of the home has resulted in management approaches that want successful teamwork amongst staff but do not provide the necessary support for that teamwork to occur

Theme #2 – Individual Characteristics & Relationships

- ❖ Open-mindedness, assertiveness, and mutual trust and respect encourage collaboration within the home
- ❖ While, a lack of confidence to contribute, closed mindedness and an overall resistance to change discourage collaboration
- ❖ Communication is vital in the collaborative process. One must be willing to talk about what they know, listen to others, solicit information when necessary, and identify who is best to communicate with in certain situations
- ❖ Strong and well developed relationships, as well as a sense of shared responsibility promoted collaboration amongst the team

Theme #3 – Valuing PSWs Contributions

- ❖ PSWs are given minimal opportunity to discuss or be involved in care planning
- ❖ PSWs feel they are often not sought out for information or asked their thoughts and/or opinions because they are 'just PSWs'
- ❖ Several PSWs have developed personal connections with the residents and want to ensure they are given the most personalized care available
- ❖ PSWs want their contributions and unique resident knowledge to be both recognized and valued by registered staff and management

Appendix E
Study Follow-up letter

Dear _____;

I am writing to thank you for your interview participation on _____. The information that you have provided will be an invaluable asset to my research. It was indeed a pleasure talking with you. My research study, titled “Personal Support Workers’ Experience of Collaboration in a Long-Term Care Facility in Rural Ontario”, is proceeding as planned and analysis is complete.

As promised in the Letter of Information & Consent Form, I have included a summary of key themes that have emerged from the interview data for your comments. Please note: the key themes identified in this summary are a result of looking at all participant data collectively; therefore, you may not have discussed a particular theme that is outlined but your colleagues may have.

I anticipate you can return this form within two weeks of receiving this package. If I have not received your returned copy or heard from you by Friday, July 11th, I will assume that you do not have any concerns and the themes regarding the experiences of collaboration have been captured accurately in the summary.

1. Please provide any feedback and/or comments you have regarding the summary of key themes in the feedback form attached below.
2. Please return the completed feedback form via e-mail to kh13uc@brocku.ca or via mail using the addressed, stamped envelope provided within two weeks of receiving the summary.

Should you have any comments or concerns, you can contact me or my faculty supervisor listed below. Also, should you wish to receive an electronic copy of the final report at the end of the study, provide an e-mail address that the report can be sent to on the form below.

Kind regards,

Student Investigator: Katie Hoogeveen, BA
Department of Community Health, Brock University
613 858 3159
kh13uc@brocku.ca

Faculty Supervisor: Dawn Prentice RN, PhD
Department of Nursing, Brock University
905 688 5550 x5161
dprentice@brocku.ca

Feedback Form

Do the key themes presented in the summary accurately depict your overall experience of collaboration in the long-term care home? If yes, please move onto the next question. If no, please explain why not.

Is there a particular theme that has been identified that does not resonate with you regarding this experience? If so, what theme and why does it not resonate with you?

Do you have any other comments and/or concerns regarding the summary of key themes that you have now reviewed?

If you wish to receive a copy of the final report, please provide an e-mail address for which it can be sent: _____

Appendix F

Ethics Clearance Form



Brock University
Research Ethics Office
Tel: 905-688-5550 ext. 3035
Email: reb@brocku.ca

Social Science Research Ethics Board

Certificate of Ethics Clearance for Human Participant Research

DATE: 10/16/2014
PRINCIPAL INVESTIGATOR: PRENTICE, Dawn - Nursing
FILE: 14-052 - PRENTICE
TYPE: Masters Thesis/Project STUDENT: Kathryn Hoogeveen
SUPERVISOR: Dawn Prentice
TITLE: Personal Support Workers Experience of Collaboration in Long-Term Facilities in Ontario

ETHICS CLEARANCE GRANTED

Type of Clearance: NEW

Expiry Date: 10/30/2015

The Brock University Social Science Research Ethics Board has reviewed the above named research proposal and considers the procedures, as described by the applicant, to conform to the University's ethical standards and the Tri-Council Policy Statement. Clearance granted from 10/16/2014 to 10/30/2015.

The Tri-Council Policy Statement requires that ongoing research be monitored by, at a minimum, an annual report. Should your project extend beyond the expiry date, you are required to submit a Renewal form before 10/30/2015. Continued clearance is contingent on timely submission of reports.

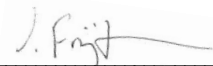
To comply with the Tri-Council Policy Statement, you must also submit a final report upon completion of your project. All report forms can be found on the Research Ethics web page at <http://www.brocku.ca/research/policies-and-forms/research-forms>

In addition, throughout your research, you must report promptly to the REB:

- Changes increasing the risk to the participant(s) and/or affecting significantly the conduct of the study;
- All adverse and/or unanticipated experiences or events that may have real or potential unfavourable implications for participants;
- New information that may adversely affect the safety of the participants or the conduct of the study;
- Any changes in your source of funding or new funding to a previously unfunded project.

We wish you success with your research.

Approved:


Jan Frijters, Chair
Social Science Research Ethics Board

Note: Brock University is accountable for the research carried out in its own jurisdiction or under its auspices and may refuse certain research even though the REB has found it ethically acceptable.

If research participants are in the care of a health facility, at a school, or other institution or community organization, it is the responsibility of the Principal Investigator to ensure that the ethical guidelines and clearance of those facilities or institutions are obtained and filed with the REB prior to the initiation of research at that site.